

Evolution Health Plan

Policy Wording

(April 2026)

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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 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 look through your policy including the detailed benefit schedule to make sure you fully understand what is covered by your insurance policy.

Your policy has been written using plain language wherever possible and has been designed to set out all 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 do not hesitate to contact us.

a. Contract of insurance

The application form you completed, together with any additional information provided, this policy wording, the certificate of insurance, any endorsements applied to the policy and the detailed benefit schedule, 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 due date, we will provide you and the persons listed in the certificate of insurance with the benefits set out in the detailed 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

- This is a list of the different parties involved in 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.

- Antea International Insurance Limited is the Insurer and underwrites all the benefits provided under the policy

through the Registrar of International Insurance in Nevis, registration number I 53876.

- Morgan Price International Healthcare Ltd is the entity appointed by the Insurer to provide the services relating to policy administration, claims handling, case management and evacuation and assistance on this policy. Authorised and Regulated in the UK by the Financial Conduct Authority (FCA) under Firm Reference Number: 313738.

c. Understanding the scope of your insurance

You will find details of what is covered and what is not covered in the detailed benefit schedule. Please make sure you read this carefully to understand what is covered and where waiting periods may apply to benefits.

In addition, within this policy wording, there is a list of general exclusions that apply to this policy.

d. Our promise of service

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

- Politeness and courtesy.
- Helpful advice and guidance.
- Confidentiality.
- Professional and efficient 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. We will always aim to provide you with a professional, confidential and efficient service no matter what your query is.

However, we do appreciate that occasionally things can go wrong. We take all complaints seriously and aim to resolve them fairly and promptly. The information in the 'How to make a complaint' section explains how you can complain and how we will deal with your complaint.

e. Cooling-off period

If having purchased this insurance, you decide that it does not meet your needs, please confirm in writing to info@morgan-price.com within 14 days of receipt of your documentation, that you wish to cancel the insurance.

Provided no claims have been paid and/or pre-authorisation of claim costs have been issued, we will refund any premium you have paid.

f. Queries on your policy

For any queries on your policy, you should contact:

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

T: +44 (0) 1379 646 730

F: +44 (0) 1379 652 794

E: 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, Antea International Insurance Limited, is the joint controller and processor of your personal data.

We 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 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.morgan-price.com 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 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 of their home country) and local nationals (i.e. persons living and/or working inside their home country) and their eligible dependants, with the exceptions 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.

Maximum age of entry at the start date of the policy on an FMU basis is 74.

Maximum age of entry at the start date of the policy on a Moratorium basis is 55.

Children can be added to a member's policy but 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.

We offer Child Only policies only to children between the age of 10 and 17.

A compulsory excess applies to these policies of \$/£ 100 per claim.

Any children under the age of 10 have to have an adult covered on the policy.

b. Conditions of acceptance

We are entitled to refuse 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.

If we cannot obtain all the information we need to assess a risk, we reserve the right to decline cover.

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 misstatement;
- Tell us straight away if anything you have already told us changes, especially between the date you apply for a policy and the date we issue it;
- 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

We assess risks in different ways as listed:

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.

We may need to request additional information to be able to provide terms. You must ensure that the FMU application form is fully and accurately completed, taking into consideration that the medical declaration relates to the whole of your life unless otherwise stated. If you are not sure whether you need to declare a condition to us or not, you should declare it.

Any pre-existing conditions not declared on your FMU application may not be covered by your policy.

If a 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 55 at the start date of the policy. If you select Moratorium Underwriting, you must complete the Moratorium application form.

Moratorium Underwriting means that you and any eligible dependants will not be covered for any pre-existing conditions that have been in existence during the 5-year period before your start date. After 2 years 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;
- And, you were not reasonably aware the condition existed.

If there is any doubt over whether a condition existed prior to the start date of the policy, we reserve the right to request a further medical opinion. The final decision on whether a condition is covered rests solely with our Chief Medical Officer (CMO).

c. Non Disclosures

What if you didn't tell us about a condition, symptom or treatment you knew about when we asked? Whichever form of underwriting you joined on, we may have asked you some medical questions before agreeing your cover. We worked out your terms or your premium based on your answers. If you did not answer fully or accurately, even if this was by accident, we will not cover treatment for the condition.

This means we will not cover treatment for any conditions that you should have told us about when we asked, but that you either did not tell us about at all, or that you did not tell us the full extent of. This includes:

- any pre-existing or previous medical condition, whether you had treatment for them or not; or
- any previous medical condition that recurs; or
- any previous symptoms that you have had or should reasonably have known about, even if you did not speak to a doctor.

Whenever you claim, we may ask your medical practitioner for more information to confirm whether you had any symptoms before you joined.

If we need to look at your medical history, we will need some time to do this before we can confirm whether we can cover your claim.

If during the course of your policy we deem that a pre-existing condition was not disclosed to us, we reserve the right to either apply retrospective exclusions to your plan or to cancel the plan back to inception.

d. Underwriting and related conditions.

Whichever type of underwriting you joined us on, then there is often a misunderstanding about what we mean by related conditions.

Below is a list of typical examples (not an exhaustive list) of the type of things we will not cover if you join us with a pre-existing condition that we have not agreed to cover in writing. This list is not exclusive.

A pre-existing condition that you may have when you take out a policy with us	Specific conditions that we will not cover whether diagnosed or not, but which we deem to be related to the pre-existing condition shown
Hypertension (whether controlled with medication or not).	<p>We will not cover:</p> <ul style="list-style-type: none"> Hypercholesterolemia Stroke Peripheral Artery Disease Heart attack Heart disease or failure of any kind
Hypercholesterolemia (whether controlled with medication or not):	<p>We will not cover:</p> <ul style="list-style-type: none"> Hypertension Stroke Peripheral Artery Disease Heart attack Heart disease or failure of any kind
Diabetes (whether controlled with medication or not).	<p>We will not cover:</p> <ul style="list-style-type: none"> Stroke Peripheral Artery Disease Heart attack Heart disease or failure of any kind Neuropathy Retinopathy Diabetic renal disease
If you are a Smoker as declared on your application form:	<p>We will not cover:</p> <ul style="list-style-type: none"> Emphysema Chronic obstructive pulmonary disease (COPD)

4 How to claim

a. Emergency assistance/evacuation claims (Pre-authorisation required)

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 contact us immediately for assistance on +44 (0) 3300 581 668 and select **Option 2**.

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

- Full name.
- Date of birth.
- Membership Number (found on your certificate of insurance).

- **Location.**
- **Name and contact details of treating physician/hospital.**
- **Details of the medical condition.**

We will make contact with your treating physician to obtain required medical information so that we can assess your medical condition and decide if medical evacuation is required and how we will need to action that. If covered, arrangements will be made and we will deal directly with any facility or evacuation 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 is practicably possible.

b. Claims requiring pre-authorisation

Within the detailed benefit schedule it is shown where certain benefits need pre-authorisation. If you wish to make a claim on one of these benefits, you need to call us on **+44 (0) 3300 581 668** and select **Option 3**, or send an email to mpclaims@morgan-price.com

In most cases, we will then be able to deal directly with the hospital/clinic to arrange your treatment and then place a guarantee of payment with the hospital and pay them directly.

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

If you do not contact us for pre-authorisation as per the detailed benefit schedule, a 25% co-insurance will apply to your claim.

If your policy has a deductible/excess or coinsurance to be applied, you will be responsible for paying the hospital directly for the costs not covered.

c. Reimbursement claims

For claims that do not require pre-authorisation, you should take a claim form with you when you receive medical treatment and request the treating physician to complete their part of the form. Settle the invoice yourself and then send us the claim form and paid invoice/receipt.

Claim forms can be downloaded from www.morgan-price.com

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

Please send the claim form and supporting documentation to us by secure email to mpclaims@morgan-price.com

Alternatively, you can post them to us at:

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

Please take a copy of your claim documents before posting us the originals.

If you want to speak to us about your claim, please call us on **+44 (0) 3300 581 668**.

d. General claims guidance notes

You only need to complete one claim form for each different medical condition per policy year. If you receive further bills for an already submitted claim, please send them in with an accompanying letter quoting your membership number and claim number already provided. Alternatively, take a copy of your original claim form and submit that with the additional bills.

When you submit your first claim, please ensure that you also send us the completed bank details form to ensure we can make payment to you. You must include an IBAN and SWIFT code where this is required.

Please note that we cannot make payments to banks in countries where UK/US Sanctions are in place.

ALL claims must be submitted within **3 months** of the date of service or treatment, otherwise they will not be considered for reimbursement.

You must provide us with written response to any request for information regarding a claim within 28 days of us asking, 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 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.

In the evaluation of medical claims, the decision of our Chief Medical Officer (CMO) is our final decision.

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 it will be applied once a year to each insured person. If you have also selected a co-insurance on out-patient benefit options, the excess will be applied to the claim first and then the co-insurance will be applied to the remaining amount. At the start of each period of insurance, you are responsible for bearing the costs for any expenses up to the value of your deductible/excess.

Please send us a completed claim form together with all the bills so that we can work out the amount payable once you have incurred eligible costs up to the level of your deductible/excess.

For members seeking treatment in the UK, helpful information about consultants and private hospitals is available on the website of the Private Healthcare Information Network www.phin.org.uk.

e. 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, unexpected, specific bodily injury caused by violent or external means.

Acute Medical Condition

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 detailed table of benefits 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, level of cover, period of insurance, inception and expiry date, name of the Insurer, any special terms, conditions and exclusions and the detailed benefit schedule, 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.

Close relative

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

Co-insurance

The percentage of eligible costs which you are responsible for paying.

Complications of pregnancy and childbirth

For the purposes of this policy complications of pregnancy and childbirth will only be deemed to include the following: toxemia, gestational hypertension, pre-eclampsia, ectopic pregnancy, hydatidiform mole, ante and postpartum haemorrhage, retained placenta membrane, stillbirths, miscarriage, emergency caesarean sections (where a physician has certified that it is medically necessary) and abortions (where a physician has certified it is medically necessary).

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 or spend most of their time each policy year.

Critical medical condition

A situation where an insured person is suffering a medical condition, which in the opinion of our Chief Medical Officer 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 does not need 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 policy year basis, which means 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.

Eligible costs

Charges, fees and expenses for all the items of benefits as displayed on the detailed table of benefits attached to your certificate of insurance.

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 sudden onset of an illness, where it is reasonable for the insured person to believe 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.

Emergency medical transfer or evacuation

Medically necessary emergency transportation and medical care approved by us when the facilities in the place of incident are not able to provide the care required. This includes medical care during the process of transporting an insured person who is suffering from a critical, life threatening Eligible medical condition to the nearest suitable hospital that can provide the necessary treatment.

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 fourteen different areas as shown in your certificate of insurance which comprise of the following countries:

Area 1: Resident outside of Asia - Worldwide excl USA, Singapore, Hong Kong & China

Area 2: Resident outside of Asia - Worldwide excluding USA.

Area 3: Resident in Asia Worldwide excl USA, Singapore, Hong Kong & China

Area 4: Resident in Asia Worldwide excl USA.

Area 5: Worldwide

Area 6: SEA Bangladesh, Brunei, Myanmar, Cambodia, India, Indonesia, Laos, Malaysia, Pakistan, Phillipines, Sri Lanka, Taiwan and Vietnam

Area 7: Africa (excluding Republic of South Africa)

Area 8: Residents of China, Thailand & Singapore - WW Exc USA

Area 9: Residents of China, Thailand & Singapore - Worldwide

Area 10: Residents of Indonesia - WW exc USA, Singapore, Hong Kong & China

Area 11: Residents of Indonesia - worldwide excl USA

Area12: Residents of Indonesia - worldwide

Area 13: Residents of Hong Kong - WW exc USA

Area 14: Residents of Hong Kong - 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 stated on the application form completed at the start date of the policy.

Hospice

A facility that specialises in the care of people who are terminally ill with special concern for death with dignity.

Hospital

Any facility 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

Antea International Insurance Limited. The Insurer is

solely obligated and liable for all covers and benefits provided under the terms of this policy wording, certificate and any endorsements.

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 will be one of the following:

- Standard
- Standard Plus
- Comprehensive
- Premium
- Elite

Lifetime limit

The maximum amount of money we will pay, during the lifetime of your policy, in respect of benefits marked with a lifetime limit on the benefit schedule attached to your certificate of insurance.

Local ambulance services

Provision of ambulance to transport an insured person 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.

Medical Practitioner

A person who is legally qualified in medical practice following attendance at a recognised medical training facility to provide medical treatment and who is licensed in the country where the treatment is received.

Newborn

A baby who is within the first 16 weeks of its life following birth.

Nurse

A registered nurse who has graduated from a nursing program and met the requirements outlined by a country, state, province or similar licensing body to obtain a nursing license, and delivers clinical treatment alongside doctors and other healthcare professionals.

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).

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-authorisation

The process whereby an insured person seeks approval from us prior to undertaking treatment or incurring costs.

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, or was reasonably aware existed, in the 5-year period prior to your start date or for your whole life in relation to full medical underwriting plans. 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 3 quotations for the disputed treatment and we will settle costs based on an average of the 3 quotations.

Waiting period

The period during, which no benefit is payable for treatment costs when a waiting period is shown in the benefit schedule. Only costs incurred after the waiting period will be eligible for consideration.

We/Us/Our

Antea International Insurance Limited, in conjunction with Morgan Price International Healthcare Ltd, who are responsible for administering this policy on behalf of the Insurer. Our claims and assistance services may be outsourced to specialist organisations who act on our behalf.

6

General exclusions

The following exclusions apply to all benefits of this policy. Please note, any consequences resulting directly or indirectly from these exclusions are also excluded.

We will not pay claims for any of the following:

1. The first 25% of costs for any claims not pre-authorised, where required.
2. Any treatment costs that occur after the expiry date of the policy.

3. 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, or was reasonably aware existed, 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.
4. Medical treatment for alcoholism, drug and substance abuse/dependency. This includes treatment for being under the influence and/or suffering from the effects of alcohol, intoxicants, drugs or narcotics.
5. Medical treatment for any addictive and/or compulsive disorder.
6. Deliberate self-inflicted injury, needless self-exposure to peril (except in an attempt to save human life), suicide, attempted suicide or self-harm.
7. Dietary supplements, nutritional supplements, body-building 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 3H Complementary Therapies and 2 Cancer Care Benefit.
8. Contraception, sterilisations or its reversal (including vasectomy), fertilisation, impotence, venereal disease (including testing), sexually transmitted diseases, gender reassignment or any other form of sexual related condition.
9. Medical treatment for any form of assisted reproduction (including in vitro fertilisation, surgical procedures, hormonal medicines) and its consequences, or complications of the assisted reproduction treatment, or complications of any resulting pregnancy and childbirth. Childbirth as a result of the above will be covered within the routine pregnancy and childbirth benefit. There will be no cover for complications.
10. Any act that is fraudulent, illegal, criminal, deliberately careless or reckless on the insured person's part.
11. Any claim arising in the course of travel undertaken against medical advice or where you could have reasonably foreseen a medical condition would arise.
12. Any claims arising from air travel when the insured person is more than 28 weeks pregnant.
13. Costs associated with medical treatment of a premature baby after the initial 2 months from date of birth.
14. Any claims arising from birth injuries or defects, congenital illness/abnormality except where covered within the detailed benefit schedule under section 8, items A and B.
15. 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 on the benefit schedule under section 4, item B.
16. Any treatment which is experimental and/or unproven. We deem this to be any treatment not recognised scientifically by the official government control agency of the country where treatment is received.
17. Any treatment and/or use of drugs/medicines not licensed by the official government control agency of the country where treatment is received or not used in accordance with their licensed indications.
18. Drug therapy and/or treatment provided by a physician who is unlicensed in the country treatment is received.
19. Routine or preventative medicines, vaccinations of any kind and general health check-ups, unless specifically covered by your selected plan type.
20. Cosmetic surgery, cosmetic treatments or remedial surgery, whether or not for psychological purposes, except when required as a direct result of an illness, injury or accident.
21. Any claims arising from weight loss, weight problems or eating disorders, including removal of fat or other surplus body tissue.
22. Any claims arising from snoring, insomnia, sleep apnoea or sleeping disorders, including sleep studies or corrective surgery.
23. 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.
24. Stem cell transplants for any medical condition apart from the treatment of cancer where it is pre-authorised.
25. Medical treatment performed by a physician who is a relative of the insured person, unless previously approved by us.
26. Claims arising from racing, other than on foot, and all professional sports (By professional we mean sports for which you and/or your covered dependants are paid to take part).

- However, we reserve the right to load for or exclude hazardous activities that must be disclosed on the application form.
27. 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.
 28. 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.
 29. Any expenses relating to an air/sea rescue operation or an evacuation/transfer from any off-shore structure or ship.
 30. 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.
 31. Any expenses where no supporting documents are available.
 32. Any accounts, bills or invoices received by us more than 3 months after the date of treatment or the date the service was given.
 33. Accommodation and medical treatment costs in a hospital where it has effectively become the insured person's home and where the admission is arranged wholly or partly for domestic reasons.
 34. Accommodation and medical treatment costs in a nursing home, hydro spa, nature clinic, health farm, health spa, rest/retirement/convalescent home or similar.
 35. Medical treatment for learning difficulties, hyperactivity, attention deficit disorder, speech therapy, behavioural problems or development problems.
 36. Any costs which are unnecessary, medically inappropriate or are over and above what is usual, customary and reasonable for the services provided. Usual, reasonable and customary will be for the area or country where treatment is received, not for the hospital itself.
 37. Any claim in any way caused or contributed to, by the use or release or the threat thereof of any nuclear weapon or device, chemical or biological agent.
 38. Any claims 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, except where injury is sustained as an innocent bystander.
 39. 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. 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.
 40. Any expense which at the time of happening, is covered by any other existing insurance plan or state cover. If there is other cover in force, the insured person must tell when they first contact us.
 41. Costs which you would have otherwise had to pay in any event.
 42. Any loss arising from the medical services in this policy, unless negligence on our part can be demonstrated.
 43. Any costs incurred where the insured person has travelled to a country/area which the Government or Embassy, of their home country, have advised against travelling to.
 44. Medical treatment related to podiatry and/or chiropody, including, but not limited to, bunions and ingrown toenails.
 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. Claims arising from the use of e-cigarettes.
 48. No cover is provided under this policy if general medical advice has not been followed. In addition, If you have been recommended to have any tests or investigations, for a medical condition whether diagnosed or not, for which you did not attend and/or cannot provide us with evidence of, then treatment of this medical condition will not be covered by us.
 49. Costs for the provision of medical reports or completion of claim forms or translations.
 50. Any motorcycle accident where a crash helmet has not been worn, whether or not it is required by law in the country of claim.
 51. Any 'over the counter' drugs or medicines available without a physicians prescription, even if medically recommended or prescribed or acknowledged as having therapeutic effects.

52. Please note, no cover is available for implantation of any other organ either of a natural or artificial nature.
53. There is no cover for any accidents or medical treatment required as a result of using electric or motorised scooters whether being driven on the road or off the road, legally or illegally.

7 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 PDF of your 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. If your newborn has known medical conditions, these will need to be declared on an FMU application form and we will advise what cover we can offer.

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, 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 1-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 as much notice as possible 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, excess or co-insurance 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 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.

We reserve the right to apply a variation in cover to any medical conditions which pre-existed the date of such change.

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, 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 11A – 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 misstatement 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. Even if your documents have been provided to you in a different language to English, the English law and wording overrides any translated documents. The courts of England and Wales alone shall have jurisdiction in any dispute.

8 How to make a complaint

If you feel we have not provided the level of service you expected, please follow the procedures outlined below:

- 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.
- You can notify us by telephone, face-to-face or in writing.

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

Email: info@morgan-price.com

Tel: +44 (0) 1379 646730

How to deal with your complaint:

- We will always respond in a courteous manner and we aim to resolve complaints within 3 business days following receipt (e.g. received Monday 10:00am, 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 have not received a final response, or you are dissatisfied with the final response you received (at any stage of the process), you can refer your complaint to the Financial Ombudsman Service (contact details are shown below).

How we will respond to your complaint:

- If we can resolve your complaint within 3 business days following receipt, you will be sent a summary resolution communication, which will confirm the matter has been resolved and details of the Financial Ombudsman Service.

- Where we have been unable to resolve the complaint within 8 weeks, 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.

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.

We expect that the majority of complaints will be quickly and satisfactorily resolved at this stage, but if you are not satisfied you can take the issue further.

If you remain dissatisfied with our response:

1) For Service or Administration Complaints Relating to Morgan Price

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

Visit their website at:

www.financial-ombudsman.org.uk

Call on 0800 023 4567 or 0300 123 9123 from within the UK, or +44 207 964 0500 from outside the UK,

Write to them or visit them at:

Financial Ombudsman Service,
Exchange Tower,
London,
E14 9SR
United Kingdom

Email them at:

complaint.info@financial-ombudsman.org.uk

You can find out more information by following the link here:

www.financial-ombudsman.org.uk/publications/ordering-leaflet/leaflet

Please note that if you wish to refer this matter to the Financial Ombudsman Service, you must do so within 6 months of the final decision.

You must have completed the above procedure before the Financial Ombudsman Service will consider your case.

2) For Product or Claims Related Complaints

Please put full details of your complaint in writing and send to:

Antea International Insurance Limited
c/o Atlas Insurance Management
Whitehall House, 3rd Floor, 238 North Church Street,
PO Box 699, Grand Cayman,
KY1-1107,
Cayman Islands

Your legal rights are not affected.

Phone: +44 (0) 1379 646730

Fax: +44 (0) 1379 652794

Email: info@morgan-price.com

Morgan Price International Healthcare Ltd

2 Penfold Drive

Gateway 11

Wymondham

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United Kingdom

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