Policy Wording

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1. Welcome

Welcome and thank you for choosing VfA Worldwide Private Medical Insurance.

This document explains:

- how your policy works
- how to manage your policy
- what is and is not covered
- how to make a claim
- if in the unlikely event you are unsatisfied, how to make a complaint
- definitions and what we mean by the words throughout this document

It is therefore a valuable document and should be kept in a safe place.

Please read the policy document and certificate of insurance carefully to make sure all the details are correct. If you have any questions about the information in this policy document please contact us as soon as possible.

The application form and declarations completed by you, together with the policy document and certificate of insurance, create a contract between the policyholder, the underwriter and us.

In return for payment of the premium, we will pay charges for pre-authorised, appropriate and medically necessary treatment for eligible medical conditions. Payment of these charges will be subject to our reasonable and customary charges and fee schedule. All treatment must be authorised during the policy period.

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2. Underwriting

Your policy is subject to different types of underwriting and we have explained what these mean to you.

a) Full medical underwriting

This is a type of underwriting where we ask you to complete a number of questions about your health.

We will review this information and decide what cover we can offer you. If necessary we may ask your Medical practitioner to provide more information to help us do this.

If you have any pre-existing conditions that may need treatment in the future, we will usually exclude them from the cover along with any condition related to them.

If you agree to the policy terms we are offering you, any exclusion we apply will be shown on your certificate of insurance and will start from your commencement date. In some cases we will advise you that an exclusion can be reviewed at your request after a specific time period, after the policy has started. Please note that if we offer to review an exclusion, this does not automatically mean that the exclusion will be removed.

With full medical underwriting new acute medical conditions arising after the start of your policy will be covered immediately subject to the policy terms and conditions.

A fully medically underwritten policy does not cover medical conditions that you and your dependants already had prior to the policy commencement date, including any related conditions that have not been disclosed and accepted by us.

It is essential that you give us all the information we ask for, even if you have symptoms that have not been diagnosed. If you don't, we will not pay any claim that you make in the future, or may even cancel your policy. If you are not sure whether or not to mention something, you should do so.

b) Moratorium underwriting

If you choose this underwriting option, you do not need to complete any questions concerning your health at the point of application, however, you will not be covered for any claims made in respect of preexisting conditions during the first two years of the policy, for which you have received treatment and/ or medication, or asked advice on, or had symptoms of whether or not diagnosed, during the two years immediately before your policy started with us.

Conditions that arise after the policy commencement date, but are related to the pre-existing condition will also be excluded.

We exclude any medical condition or related condition which:

- was foreseeable,
- manifested itself,
- you have experienced signs or symptoms of,
- you have sought advice for, or
- you have received treatment and / or medication for,
- to the best of your knowledge, existed

in the two years before the start of the insured persons cover.

If you have:

- experienced symptoms,
- sought advice,
- required treatment, medication, or special diet, or,
- received treatment, medication, or special diet

in the 2 years after the policy commencement date, then you will have to wait until you have completed a continuous 2 year period where you have not;

- experienced symptoms,
- sought advice,
- required treatment, medication, or special diet, or,
- received treatment, medication, or special diet

in order for the medical condition or related medical condition to be considered for coverage.

3. How to manage your policy

This policy is available to persons (subject to age limitations) and their dependants in countries where the underwriter is legally permitted to transact Private Medical Insurance. This policy is not available to citizens of the USA residing in the USA, those persons who are subject to exchange controls or where the purchase of this policy is illegal under local legislation.

The minimum age at entry for a policyholder is 18 years attained. In the case of an applicant being under the age of 18 years attained, a parent or guardian is required to sign the application form and will be considered to be the policyholder and will be charged the 18 year old rate. No discounts will apply.
The maximum age of entry is 70 years.

The maternity benefit is only available to female members aged 18-44.

Paying the Premium

The policy is an annual contract and premiums are payable either monthly, quarterly or yearly in advance.

Premiums are payable in GB pounds (£), US dollars ($) or Euros (€) and the Policy will be denominated in the currency in which the premiums are paid.

Methods of Premium Payment

For yearly premium payments, you can choose to pay by:

- Credit Card (Visa or Mastercard).
- Direct Debit (EU bank account holder only).
- Annual Debit.

For monthly premium payments, you can choose to pay by:

- Credit Card (Visa or Mastercard).
- Direct Debit (EU bank account holder only).

For quarterly premium payments, you can choose to pay by:

- Credit Card (Visa or Mastercard).

Completing our Credit Card or Direct Debit instruction authorises us to debit your account with the appropriate premium due, depending on the premium frequency chosen. You are also authorising us to process subsequent renewal premiums as notified by us until we receive written instructions that you wish to alter the method of payment, or cancel the Policy.

You are responsible for keeping us informed of your current credit card details. You must notify us when changes are made to your credit card details to ensure that we can continue to collect your premiums.

Direct Debits can only be accepted from UK bank accounts for Policies denominated in GB pounds (£).

In the event of us being unable to collect a premium by Direct Debit or Credit Card in any month, for whatever reason, it may be necessary for us to collect more than one premium at the next payment date.

Unpaid or Late Premium Payments

In order for you to enjoy the benefits of your policy, you must pay your premiums on or before the due date. If you do not pay the premium by the due date, all claims will be suspended until the premium due is paid.

If the premiums remain unpaid after 30 days from the premium due date, the policy will be cancelled.

We will notify you in writing when the premium payment is outstanding.

If we cancel the plan, you will have to re-apply for a new plan. Premium rates in force at the time of re-application will be charged and cover may be subject to new underwriting terms.

Cancellation

If you decide that this policy is not suitable for your needs, you can cancel the policy within 14 days (cooling off period) of receiving your policy documents or from your policy commencement date, whichever is the later. You will need to send the policy cancellation request in writing by letter, fax or email.

If you incur eligible claims costs within an insured period and cancel within that period we reserve the right to reclaim monies paid on an eligible claim.

We will cancel the policy from the date we receive the cancellation request or on a date in the future. We will not backdate the cancellation date of the policy.

We also reserve the right to cancel the policy if you:

- fail to pay the premium,
- fail to observe the policy terms including a change of circumstances;
- misled us by mis-statement, deception or concealment;
- fail to act with utmost good faith;
- attempted, alone or with a third party, to obtain money unreasonably at our cost;
- if you are a citizen of the USA and spend more than 180 days continuously In the USA.

We may also cancel the policy if changes occur regarding the national health insurance law or other legal general regulations which affect the policy fundamentally and subsequently no further basis for the policy exist.

Change of circumstances

You must inform us as soon as possible of any changes in your circumstances or any insured person's circumstances for instance;

- change of name,
- change of address,
- change of occupation,
- any material fact which may affect the premium or the terms of the agreement.

We reserve the right to cancel or amend the terms or premium of the policy upon notification of such changes.

Adding and removing dependants

Subject to our acceptance, you can apply to add your dependant onto your policy. Any request must be made in writing by letter, fax or email and you must tell us about all material facts.

If the dependant is a new born child, born during the policy period then as long as you have notified us of the request before the child is 3 months old and you have told us of all material facts, which we accept, we will not apply a moratorium on pre-existing medical conditions.

At the renewal date, we will remove a dependant (child) on your policy if they are 21 years of age (or 25 if they are in full-time education). They may apply for their own policy and as long as there has been no break in coverage, their inception date will stay the same. Any application is subject to our acceptance.

Renewal

Your Policy is an annual contract. You are normally invited to renew your policy one month prior to the expiry of the one year period. Renewal of your policy is at our discretion and subject to our acceptance.

We reserve the right to change the terms and conditions of the policy and such changes will be advised to you when we invite you to renew.

Premiums are normally reviewed annually and are always based on the insured person's age, medical considerations and general inflation.

If you wish to amend your chosen benefits, currency, premium frequency or excess you can request to do so at renewal and subject to our acceptance.

Any change to your area of coverage at renewal is subject to our acceptance.

Death

If the insured person dies, there will be no premium refund under the policy, although valid claims will still be paid in accordance with the terms and conditions of this policy. Subject to our agreement and if requested, we can transfer the policy to the insured spouse or dependants, if over the age of 18.

4. General policy conditions

1. This policy provides benefit for reasonable and customary costs of eligible acute medical conditions as outlined in the benefits you have chosen. If your policy does provide cover for chronic medical conditions, the limits available will be specified on your table of benefits.
2. We will pay benefit for eligible new medical conditions that arise after the acceptance and commencement of cover, as stipulated in the certificate of insurance. The basis of underwriting acceptance is stated on the certificate of insurance.
3. All treatment and diagnostic tests must be by and under the care of specialists following referral by a Medical Practitioner.
4. All in-patient, day-patient (except emergency treatment) and claims made under the medical evacuation and repatriation benefit must be pre-authorised by us. Failure to pre-authorise treatment will result in services being paid at 50% of the costs incurred.
5. Benefits will be paid net of any excess agreed under the terms of the policy.
6. The limits on the table of benefits will be denominated in the currency in which the premiums are paid.
7. If you have not provided your medical practitioners details on your application form and you make a claim that we consider is a pre-existing medical condition based on the opinion of our Chief Medical Officer, then we will be unable to consider the claim for benefit.
8. We reserve the right to require you to get a second opinion from a Specialist of our choosing. We will be responsible for the Specialist's costs for the second opinion.
9. If you choose to have your treatment by a visiting medical practitioner and their fees are considered not reasonable and customary, you will have to pay the difference.
10. Your policy will be cancelled if you have worldwide including USA cover, are a citizen of the USA and spend more than 180 days continuously in the USA.
11. All correspondence about this policy will be sent to the policyholder at your last known address. If you do not receive this any changes we have made will still be valid.
12. When dealing with a claim, we will always correspond and communicate directly with the claimant, if aged 18 years or over. If the clamant is under 18 years of age, we will communicate directly with the policyholder.
13. If we have settled costs towards a claim you have submitted to us, we will be unable to return the original documents to you.
14. It is a condition of this policy that all material facts must be disclosed to us before we accept an application, make any changes to the policy or renew the policy. If you are unsure that a fact is material, then we recommend that you advise us for your own protection.

    Please note, if you choose moratorium underwriting at the time of your application and advise us about any pre-existing medical conditions you may have, the moratorium underwriting terms will still apply to any pre-existing condition.

    Failure to disclose a material fact which would have affected our assessment of the risk, may lead us to cancel the policy and not pay any benefits in respect of a claim.

    If we cancel the policy due to you not disclosing a material fact, we will refund the premium amount paid, less any benefit paid out on a claim. If the amount of benefit paid on a claim is more than the premium paid, you will need to reimburse us the additional amount we have paid.
15. If there is or has been any fraud, untrue statements or concealment of facts either before or after the policy started, we will cancel the policy and any benefit paid on a claim must be returned to us.

    If we have evidence that you have made a claim, which is false, fraudulent or intentionally exaggerated, we will not pay any benefits for that claim.

    If you suspect fraud, then you must notify us immediately.
16. If we ask for more information to support a claim, this must be provided or we may not pay your claim. If we require any medical certificates, information, evidence and receipts, these must be obtained by the insured person at their expense. We reserve the right to ask for additional information from your medical practitioner, consultant, specialist, other physician and/or request third party opinions as often as we may reasonably require.
17. We reserve the right to re-evaluate a claim already pre-authorised should new information be received or disclosed. If this new information confirms that a claim is not valid under the policy, we have the right to recover any costs already paid towards the claim from you. Any pre-authorisation we may have given could also be withdrawn.
18. We may be unable to arrange a medical evacuation if a local situation makes it dangerous, not practical or impossible.

19. If any other insurance or indemnity covers the treatment for which the Insured Person is claiming benefit, we will only pay our share after that cover has been exhausted.

20. We have full rights of subrogation and may institute proceedings in your name, but at our expense, to recover, for our benefit, the amount of any payment made under another policy.

21. You shall not institute any legal proceedings to recover any amount under the policy until at least 60 days after the claim has been submitted to us and not more than 2 years from the date of this submission, unless otherwise required by mandatory legal regulations.

22. You must inform us as soon as possible if the medical condition for which a claim is being made is, or may be, the fault of a third party. In these circumstances:

    a) We may start legal proceedings in the insured person's name but at our expense to recover any benefits paid under this Policy.

    b) The Insured Person must give us all the necessary assistance and information to start legal proceedings or to settle or defend the claim.

    c) The Insured Person must refund to us any compensation received or due relating to your claim up to the benefit amount paid by us.

23. If we decline a claim under the policy, the onus to prove the claim is covered is the responsibility of the insured person.

24. We do not accept proof of posting an application form, claim form or premium payment as proof that we have received it.

25. The issuance of the policy document and certificate of insurance is evidence that the contract is in force.

26. If you lose your policy documents, we may charge an administration fee to re-issue.

27. Your Policy is bound by English Law.

5. Data protection

Data Protection Notice

This section contains important information about your personal details. Please make sure to show it to anyone covered by the policy and ensure they are aware that their personal details may be provided to us..

VfA is a data controller in respect of your personal information. We will process the details you have given us in line with the GDPR Data Protection laws and any other laws that apply. We may work with partner organisations and service providers who are located in other countries, and as a result your information may be processed outside the European Economic Area. In all cases we will make sure that your information is adequately protected. Any transfers of personal information outside Europe will be subject to the provisions of the US Privacy Shield, standard contractual clauses approved by the European Commission or other contracts which provide equivalent protection.

Where we collect your personal information

We might collect personal information about you from:
- You
- Other companies in the insurance market
- Anti-fraud databases, sanction lists, court judgement and similar databases
- Government agencies
- In the event of a claim, witnesses, experts, loss adjusters, legal advisers and claims handlers.

How we use and disclose your personal information

To assess the terms of your insurance contract, or to deal with any claims, we may need to share information like your name, address, date of birth and details such as medical conditions.

The recipients of this information could include (but are not limited to) credit reference agencies, anti-fraud databases, brokers / reinsurance brokers, other insurers / reinsurers, underwriters and other group companies who provide administration or support services.

For claims handling, the recipients could include (but are not limited to) external claims handlers, loss adjusters, legal and other expert advisers, and third parties who are involved in the claim.

More information about these disclosures is set out below.

The Data Protection laws classify information about your medical conditions, disabilities and criminal convictions as ‘special category’ personal data which warrants extra protection. We will only share this kind of personal data where it is essential to administer your insurance contract or deal with any claims, or for antifraud purposes and will only be used in accordance with appropriate laws and regulations. Most of the personal information you provide to us is needed for us to assess your request for insurance, to enter into the insurance contract with you and then to administer that contract. If we need your consent to use any specific information, we will make that clear at the time we collect the information from you. You are free to withhold your consent or withdraw it at any time, but if you do so it may impact upon our ability to provide insurance or pay claims.

6. Your guide to cancer coverage

Cancer treatment

We want you to have a clear understanding on what is covered and what is not covered for cancertreatment under your policy and have provided guidance below. However, if you need treatment for cancer then please call our Claims Helpline and one of our claims team will be able to help guide you through the coverage available.

What is covered for cancer?

The following treatment is covered to achieve a cure or reach remission. If you have available benefit under the chronic medical condition benefit and the terminal illness benefit, you will also be covered for the below if your cancer is being maintained or the treatment is to relief the symptoms:

- Consultations, diagnostic tests to establish the diagnosis.
- Surgery. Surgery must be widely recognised as a safe and effective treatment.
- Chemotherapy and radiotherapy drugs provided that these are used within normal clinical practice. Acceptable chemotherapy drugs are drugs that have been approved for use in the NHS by NICE (National Institute for Health & Clinical Excellence), are used within their licensed indications, as licensed by EMEA (European Medicines Agency) or MHRA (Medicines & Healthcare products Regulatory Agency) and for combinations of drugs, the drugs must have been shown to be effective in actively treating the type of cancer the patient has.

- Hormonal and biological therapies, e.g. Monoclonal antibodies, such as Herceptin, if licensed with the EMEA. They must be ap proved by the National Institute of Health and Clinical Excellence (NICE) and be used for the purpose for which they are currently licensed and widely available within the NHS. If used in combination with other drugs, hormonal and biological therapies will only be considered if these combinations are widely recognised for use within the NHS.
- Follow-up consultations and monitoring for a period of 5 years once treatment to achieve a cure or to reach remission has ceased.
- Breast reconstruction and surgery to improve symmetry, following a mastectomy or lumpectomy. We will pay for such operations for a period of up to 24 months following initial surgery.

What is not covered for cancer?

- Drugs that are still under trial or trials of combination drug therapies. These can be defined as experimental.
- Surgical and non-surgical treatment of cancer that is not recognised for treating that particular type of cancer.
- Maintenance or long-term treatment where the condition is stable, remains in remission, or remission and a cure cannot be achieved.
- Treatment of cancer where the intent is to provide relief of symptoms.
- Treatment costs that exceed the procedure limits or policy limits (if applicable).
- Where you have a recurrence of cancer, we will ask your specialist for specific information about the intent of treatment to determine whether your claim remains eligible for benefit.

Guidance

If your cancer comes back, we will assess your medical condition and proposed treatment as a new episode of treatment and will follow the same process in assessing the eligibility of your claim.

Where the intent of treatment is to provide relief of symptoms, rather than attempting to cure the benefit will be provided under the chronic condition benefit or the terminal illness benefit if available.

We have provided you with some examples in order to help explain further. All examples assume that the medical condition is eligible under the policy and benefit is available.

Example 1

Beverley has been with VfA for five years when she is diagnosed with breast cancer. Following discussion with her specialist she decides to have the breast removed followed by breast reconstruction. Her specialist also recommends a course of radiotherapy and chemotherapy. In addition she is to have hormone therapy tablets for several years.

Will her insurance cover this treatment plan and are there any limits to the cover?

We would cover the cost of mastectomy and breast reconstruction.

We would then cover the course of radiotherapy and chemotherapy drugs provided that these are used within normal clinical practice. The hormone tablets would also be eligible for benefit.

Example 2

Cara has previously had a breast cancer which was previously treated by lumpectomy, radiotherapy and chemotherapy under her existing policy. She now has a recurrence in her other breast and has decided to have a mastectomy, radiotherapy and chemotherapy.

We would cover her for the mastectomy, radiotherapy and chemotherapy. The course of radiotherapy and chemotherapy drugs would be covered provided that these are used within normal clinical practice.

Example 3

Monica, who was previously treated for breast cancer under her existing policy, has a recurrence which has spread to other parts of the body. Her specialist has recommended the following treatment plan:

- *A course of six cycles of chemotherapy aimed at destroying cancer cells to be given over the next six months.*
- *Monthly infusions of a drug to help protect the bones against pain and fracture. This infusion is to be given for as long as it is working (hopefully years).*
- *Weekly infusions of a drug to suppress the growth of the cancer. These infusions are to be given for as long as they are working (hopefully years).*

Will her insurance cover this treatment plan and are there any limits to the cover?

We will provide benefit for the six cycles of chemotherapy provided that these are used within normal clinical practice and where the treatment is given with curative intent and is not experimental.

We do not provide benefit for preventative treatments such as the monthly infusions as described. However, whilst undertaking chemotherapy we would provide funding as necessary.

We would provide benefit for the weekly infusion under the chronic medical condition benefit if benefit available, as the drug is not being given with curative intent.

Example 4

John has been diagnosed with end stage cancer and would like to be admitted to a hospice for care aimed solely at relieving symptoms.

Will his insurance cover this and are there any limits to the cover?

We would provide benefit for the admission to the hospice under the terminal illness benefit.

7. Your guide to chronic medical conditions coverage

If you have a chronic medical condition, where the purpose of treatment is to keep the symptoms under control and a cure is not possible, benefit will be provided under the chronic condition benefit if available.

Guidance

What do we mean by a chronic condition?

We define a chronic medical condition as:
a disease, illness, or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

What does this mean in practice?

When you become ill with a medical condition for the first time, we will provide coverage for the treatment (if eligible under the policy) to stabilise your medical condition. Once your condition has stabilised and the treatment you are receiving appears only to be monitoring you, or controlling your medical condition, rather than curing it, then benefit will be provided under the chronic condition benefit if available.

What if your chronic condition gets worse or becomes unstable?

If your chronic medical condition becomes unstable and gets worse, we will provide cover in order that your chronic medical condition can be stabilised as outlined under the chronic condition benefit if available.

We have provided you some examples in order to help explain further. All examples assume that the medical condition is eligible under the policy and benefit is available.

Example 1

Alan has been with VfA for many years. He develops chest pain and is referred by his GP to a specialist. He has a number of investigations and is diagnosed as suffering from angina. Alan is placed on medication to control his symptoms.

Will Alan be covered?

We will cover Alan's initial consultations and tests to obtain the diagnosis. We will also cover further consultations with his specialist until his symptoms are under control and being maintained. Any treatment to control and maintain the symptoms, will be covered under the chronic condition benefit if available.

Two years later, Alan's chest pain recurs more severely and his specialist recommends that he has a heart bypass operation.

We will provide cover for the surgical procedure. We will also cover the post-operative check-ups to ensure that the medical condition has been stabilised. Once the medical condition has been stabilised, we will provide cover for the routine follow-ups required under the chronic condition benefit if available.

Example 2

Eve has been with VfA for five years when she develops breathing difficulties. Her GP refers her to a specialist who arranges for a number of tests. These reveal that Eve has asthma. Her specialist puts her on medication and recommends a follow-up consultation in three months to see if her condition has improved. At that consultation Eve states that her breathing has been much better, so the specialist suggests she have check-ups every four months.

We will cover the consultations and tests and will also agree to pay for the three-month check-up. Once the medical condition has been stabilised, we will provide cover for the routine follow-ups and medication needed to control the medical condition under the chronic condition benefit if available.

Eighteen months later, Eve has a bad asthma attack.

We would provide cover for admittance to hospital, if medically necessary, and the treatment provided to stabilise the medical condition.

Example 3

Deirdre has been with VfA for two years when she develops symptoms that indicate she may have diabetes. Her GP refers her to an endocrinology specialist who organises a series of investigations to confirm the diagnosis, and she then starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments to the medication regime, the specialist confirms that the condition is now well controlled and explains that he would like to see her every four months to review the condition.

We will pay for the treatment of the diabetes. When the specialist confirms that the condition is well controlled and only needs to see Deirdre every four months, cover for this routine monitoring will be provided under the chronic condition benefit if available.

One year later, Deirdre's diabetes becomes unstable and her GP arranges for her to go into hospital for treatment.

We would provide cover for admittance to hospital and the treatment provided to stabilise the medical condition.

8. What is not covered

Unless otherwise specified in your table of benefits, any written policy endorsement or agreed by us, the policy does not cover claims arising from or connected with the following policy exclusions:

Please read this section carefully in conjunction with the table of benefits and the certificate of insurance.

1. A benefit not available on your policy.
2. A benefit where you have not satisfied the waiting period.
3. Amounts claimed in excess of the overall maximum annual limit for any given policy year. Any continuing treatment or other medical conditions are excluded thereafter.
4. Any consequential loss.
5. Any form of treatment or drug therapy which in our reasonable opinion is experimental or unproven based on generally accepted medical practice.
6. Assisted reproduction including In vitro fertilisation (IVF).
7. Burial, cremation or transportation where death of an insured person occurs in their home country.
8. Care and/or treatment of drug addiction or alcoholism and/or disease, illness or injury a medical condition directly or indirectly arising from alcohol, drug or substance abuse or dependency.
9. Charges made by a Specialist/Consultant or Hospital that we do not regard as Reasonable or Customary.
10. Congenital birth defects, including the correction of congenital abnormalities unless otherwise specified.
11. Consultations performed, as well as any drugs or treatments prescribed, by you, your spouse, parents or children.
12. Complementary treatment or alternative therapies, including but not limited to ayurvedic medicine, rolfing, massage, pilates, yoga, fango therapy, milta therapy and energy therapy, with the exception of those treatments indicated in the table of benefits and cover is available.

13. Cosmetic or plastic surgery or any treatment arising from it, whether or not for medical/ psychological purposes. The only exception is re-constructive surgery necessary to restore function or appearance after a disfiguring accident, or as a result of surgery for cancer, if the accident or surgery occurs during the insured members membership.
14. Cryopreservation, implantation or re-implantation of living cells or living tissue, whether autologous or provided by a donor
15. Dental implants
16. Eating disorders.
17. Expenses for the acquisition of an organ including, but not limited to, donor search, typing, transport and administration costs.
18. Expenses incurred because of complications directly caused by a medical condition or treatment for which cover is excluded or limited under the Policy.
19. Failure to follow medical advice, prescribed care and complications arising from ignoring such advice. This includes failure to follow advice against, travel, activity, action or pursuits.
20. Foetal surgery including treatment on mother or unborn child.
21. Genetic testing.
22. Growth hormone treatment.
23. HIV/AIDS/related conditions
24. Home visits unless they are necessary following the sudden onset of an acute illness, which renders the insured incapable of visiting their medical practitioner, physician or therapist.
25. Infertility treatment unless otherwise specified.
26. In-patient treatment for multiple birth babies born as a result of medically assisted reproduction is limited to £20,000 per child for the first 3 months following birth. Out-patient treatment will be covered under the limits of the out-patient benefit. The newborns must have been added to the policy within 30 days from birth.
27. Investigations into and treatment of obesity.
28. Investigations into and treatment of loss of hair and any hair replacement unless the loss of hair is due to cancer treatment.
29. Investigations of and treatment for sexually transmitted diseases.
30. Investigations into, treatment and complications arising from sexual dysfunction, impotence, sterilisation and contraception, including insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons. The only exception is the prescribing of contraceptives for the treatment of acne, where prescribed by a dermatologist.
31. Learning difficulties, behavioural and development problems.
32. Medical conditions and the consequences thereof, as well as instances of death that are caused by the misuse of alcohol or drugs by the insured person.
33. Medical error/medical negligence.
34. Medical practitioner fees for the completion of a claim form or other administration charges.
35. Myopia, hypermetropia, astigmatism, natural/non¬medical degenerative sight defects, non-medical/ natural degenerative hearing defects, aids to assist eye sight and hearing, contact lens solutions/ liquids and eye drops.
36. Natural perils and nuclear risks.
37. Non-emergency transportation.
38. Orthodontic treatment, unless otherwise specified.
39. Orthomolecular treatment.
40. Palliative treatment or treatment for chronic medical conditions unless you have the available benefit in your Table of Benefits.
41. Pandemic.
42. Personal Medical Exclusions.

43. Phobias.

44. Placing yourself in needless danger.

45. Podiatry and chiropody.

46. Pre- and post-natal classes or any other educational classes.

47. Pre-existing medical or related medical conditions (unless we have accepted to underwrite you on a Medical Histories Disregarded (MHD) basis):

    a) If you are underwritten on a moratorium, also known as (MORI), the following applies.
    We exclude any medical condition or related condition which:

    - was foreseeable,
    - manifested itself,
    - you have experienced signs or symptoms of,
    - you have sought advice for, or
    - you have received treatment and / or medication for,
    - to the best of your knowledge, existed

    in the two years before the start of the insured persons cover.

    If you have:

    - experienced symptoms,
    - sought advice,
    - required treatment, medication, or special diet, or,
    - received treatment, medication, or special diet

    in the 2 years after the policy commencement date, then you will have to wait until you have completed a continuous 2 year period where you have not;

    - experienced symptoms,
    - sought advice,
    - required treatment, medication, or special diet, or,
    - received treatment, medication, or special diet

    in order for the medical condition or related medical condition to be considered for coverage.

    b) If you are underwritten on Full Medical Underwriting also known as (FMU), the following applies:

    We exclude any pre-existing condition, or any related condition unless you have notified us of the condition when you applied for cover and we did not apply an exclusion on the insured persons certificate of insurance. Any medical exclusion we have applied is shown on the certificate of insurance.

    c) If you are underwritten on a Continuous Personal Medical Exclusion (CPME) or Switch Moratorium, the following applies:

    Members who are previously insured and have transferred to us without a break in cover are subject to the pre-existing conditions applied by the previous insurer or the moratorium date applied by your previous insurer. Please refer to points a or b above.

48. Preventative treatment or procedures.

49. Products classified as vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary consultations and supplements, including, but not limited to, special infant formula and cosmetic products, even if medically recommended or prescribed or acknowledged as having therapeutic effects.

50. Products that can be purchased without a doctor’s prescription.

51. Removal of fat or healthy tissue from any part of the body whether or not it is needed for medical or psychological reasons (including but not limited to breast reduction).

52. Routine pregnancy or childbirth, unless otherwise specified.

53. Self-inflicted conditions or any injury incurred from attempted suicide.

54. Services or treatment at any long term care facility, nursing home, spa, hydro-clinic, sanatorium, recovery centre that is not a hospital. Even if the stay is medically prescribed.

55. Sex change or gender reassignment whether or not for psychological reasons.

56. Ship to shore transportation costs.
57. Sleep apnoea, snoring, sleep disorders and sleep-related breathing disorders.
58. Speech therapy, unless in the context of a diagnosed physical impairment, such as, but not limited to, nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate). We do not pay for speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.
59. Surgical/medical appliances, such as aids or equipment, including optical and hearing aids, dentures and dental appliances. Artificial apparatus or prostheses inserted during a surgical procedure are covered.
60. Travel costs to and from medical facilities (including parking costs) for eligible treatment, except any travel costs covered under local ambulance, medical evacuation and medical repatriation benefits.
61. Termination of pregnancy except in the event of danger to the life of the pregnant woman.
62. Terrorism whether or not this involves the use or release or threat of any nuclear weapon or any chemical or biological agents.
63. Treatment as a consequence of criminal activity.
64. Treatment for conditions such as conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behaviour, obsessive-compulsive disorder, attachment disorders, adjustment disorders, as well as all treatments that encourage positive socialemotional relationships, such as communication therapies, floor time and family therapy.
65. War, riots, civil disturbances, terrorism or acts against any foreign hostility, whether war has been declared or not.
66. Treatment in the USA is not covered, if we know or suspect that cover was purchased for the purpose of travelling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover.
67. Treatment or diagnostic procedures of injuries arising from an engagement in professional sports.
68. Treatment outside the geographical area of cover unless for emergencies and/or authorised by us.
69. Treatment undertaken solely at your request.
70. Treatment undertaken without the referral of a medical practitioner.
71. Treatment that has taken place:
    - before your commencement date;
    - after your end date unless you have renewed with us and paid your premium due and the medical condition is eligible;
    - if you have not paid the premium due.
72. Triple/bart's, quadruple or spina bifida tests, except for women aged 35 or over who have purchased the maternity benefit and have satisfied the waiting period .

9. How to make a claim

Before making a claim please read this policy document, including your table of benefits to see if you have the relevant coverage available to you.

If you have any questions concerning coverage, please call the international helpline.

+49 (0)451 70 73 67 12

1. Medical evacuations or emergency inpatient/day patient pre-authorisation

In a medical emergency where you require admittance to a hospital or a medical evacuation, you or your representative must contact the International Claims Helpline immediately.

2. In/day-patient claims

In-patient and Day-patient treatment will be paid direct to the medical practitioner, consultant, hospital or clinic. This means that you will not need to pay for any treatment unless you have an excess or co-payment on your policy, or the treatment is in-eligible, or your benefit has been exhausted.

You must obtain pre-authorisation for any in-patient or day-patient treatment. Failure to preauthorise treatment will result in services being paid at 50% of the costs incurred (exept for emergency treatment).

Pre-authorisation process:

- The claims procedure will start at the time your medical practitioner refers you to a specialist. You must tell your medical practitioner that you wish to have private treatment.
- Contact the international claims helpline on +44 (0) 1992 444 337
- A member of our claims team will take your details.
- Please have your policy number, as shown on your card, ready when you phone.
- We will then contact your medical practitioner and the hospital or clinic concerned to ensure arrangements are in place for your treatment.
- We will then confirm authorisation and the arrangements that have been agreed for your treatment. You will not need to complete any claim forms.
- Receive your treatment at the hospital or clinic.

3. Out-patient claims

You must pay the hospital or clinic for your out-patient treatment. We will then settle the expenses that you have incurred, apart from any excess or co-payment, subject to your policy terms and conditions. Invoices must be send to us 6 months after you have received the invoice.

If you need any help or advice, please contact the claims team on the numbers provided. You do not need to contact the international claims helpline for pre-authorisation.

- See your medical practitioner, therapist, specialist or consultant in the normal way.
- Settle your bill for the treatment you have received.
- Complete a claim form. You can obtain a claim form by contacting the international claims helpline:
  +49 (0)451 70 73 67 12
  leistung@vfa-international.de or by downloading a claim form from:
  www.vfainternational.de
- Ensure you send your fully completed claim form along with the original itemised invoice and an original receipt to the claims department.
- Send your claim to the claims department by post at the address shown below. You must send the following items to make sure we can consider your claim:
  - A fully completed medical claim form.
  - The original itemised invoice(s).
  - The original receipt(s).
  - A copy of the prescription if medication forms part of the claim.

Claims Department contact details

International claims helpline for assitance:
+44 (0) 1992 444 337
medicalops@intana-assist.com

All other claim enquiries:
corporateteam@Intana-assist.com

10. Complaints procedure

Our commitment to you

At VfA-International 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 are committed to providing you with excellent service and exceeding our customers expectations.

If for any reason you are not entirely satisfied with any aspect of our service, please let us know.

We shall work to correct matters as quickly as possible and where appropriate, take steps to prevent the problem happening again. We value our customers and your feedback can help us improve the products and services we offer to you.

Your complaint will be investigated by an employee of competence not involved in the subject matter of the complaint.

We shall aim to resolve all complaints by close of business on the business day following receipt of the complaint. If we cannot resolve the complaint within this time due to us needing to carry out more indepth investigations, we shall:

1. Acknowledge your complaint in writing within 5 working days with either a full response or information about the progress of the matter and a contact name for future reference.

2. We will issue our final response, in writing, within 10 days after we have made a decision on the complaint and at the latest within two months of receiving the complaint.

Definition of a complaint

A complaint shall mean a statement of dissatisfaction submitted by a user of a financial service due to delays, neglect or any other failing in the functioning of the financial institution against which the complaint is filed. It also includes complaints, with a view to obtaining compensation for the harm to the user's interest or right, for specific facts about acts or omissions, which are detrimental for the user and that, arise from breaches of the regulations on transparency and customer protection, or of good practices in financial business.

A complaint must be submitted to the insurer in writing in order for it to be considered a complaint.

There is no definition of a „complainant" but any individual person or corporate entity that has a right or interest in a policy (e.g., policyholder, insured, beneficiary, third party claimant) is entitled to submit a complaint to an insurer.

Complaints contact

Branch manager
Sompo International Insurance Europe (Spain)
Carrer de Tarragona 149–157
Floor 6, Office 1
E-08014 Barcelona
Spain

Complaints from individuals and corporate entities may be referred to the insurance regulator, the Directorate General of Insurance and Pension Funds (DGS). The DGS deals with complaints in respect of mass risks written by local and EEA insurers.

Dirección General de Seguros y Fondos de Pensiones / Directorate General of Insurance and Pension Funds
Paseo de la Castellana, 44
28046 Madrid
Spain

11. Definitions

Abuse

Improper or excessive use of alcohol, drugs or any other intoxicating substance. This includes the use of drugs in quantities other than as directed or prescribed on medical authority or for a reason other than it is originally intended.

Accident

An injury which is the result of an unexpected event independent of the will of the insured and which arises from a cause outside the individual's control. The cause and symptoms must be medically and objectively definable, allow for a diagnosis and require therapy.

Accidental death

A single sudden and unexpected event which occurs at an identifiable time and place during the Policy Period and which causes unexpected bodily Injury at the time it occurs, and which solely and independently of any other cause results in the Death of the Insured Person upon its occurrence.

Accidental dental injury

A sudden unforeseen external blow to the face, teeth or jaws which occurs at an identifiable place and time resulting in dental injury.

Acute medical condition

A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

Advice

Any consultation regarding any symptoms or abnormalities that you have experienced from a Medical Practitioner, Specialist, therapist or allied healthcare specialist, or otherwise.

Appropriate

a) The type, level, length of service, and setting needed to provide safe and adequate care.

b) Rendered in accordance with generally accepted medical practice and professionally recognised standards.

c) Not generally regarded as experimental, investigational or unproven by recognised medical professionals or appropriate government agencies.

d) Specifically allowed by laws which apply to the provider who renders service.

If there is any doubt as to the appropriateness of treatment in respect of a claim, appropriateness shall be decided by our Chief Medical Officer.

Benefit

The maximum amount we will pay under the policy and as shown in the table of benefits. The charges must be reasonable and customary.

Cancer

A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue. Please refer to our cancer guide to understand the coverage provided for the treatment of cancer.

Certificate of Insurance

The document accompanying this Policy which lists the Insured Persons, the Commencement Date and any endorsements.

Chronic condition

A disease, illness or injury which has at least one of the following characteristics:

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests;
- It needs ongoing or long-term control or relief of symptoms;
- It requires your rehabilitation or for you to be specially trained to cope with it;
- It continues indefinitely;
- It has no known cure;
- It comes back or is likely to come back.

Claim

The costs incurred relating to a course of treatment undergone in relation to a specific acute medical condition that we have pre-authorised in writing as an eligible benefit under the policy.

Claimant

An insured person who had made a claim under the policy.

Close family member

A dependant, parent, step-parent, parent-in-law, grandparent, grandchild, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law or legal guardian.

Commencement date

This is the date of the commencement of the contract with us, as stipulated in your Certificate of Insurance.

Complementary treatment

Therapeutic and diagnostic treatment that exists outside the institutions where conventional medicine is taught. Such medicine includes chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy and acupuncture as practiced by approved therapists.

Co-payment

The percentage of the costs which the insured person must pay.

Critical

An unstable and serious medical condition, where the outcome cannot be medically predicted, prognosis is unclear and death could happen.

Day-patient

A patient who is admitted to a hospital or Day-Patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.

Dental prostheses

Includes crowns, inlays, on lays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

Dental surgery

Includes the extraction of teeth, apicoectomy, as well as the treatment of other oral problems such as congenital jaw deformities (e.g. cleft jaw), fractures and tumours. Dental surgery does not cover any surgical treatment that is related to dental implants.

Dental treatment

Includes an annual dental check up, simple fillings related to cavities or decay and root canal treatment.

Dependant

Your husband, wife, partner or unmarried child included on your policy. By partner we mean a person with whom you are cohabiting on a permanent basis. By child we mean you or your partner's unmarried own, adopted or step children who are under 21 (or 25 in the case of students enrolled if in full time education).

Diagnostic test

Investigations, such as X-rays or blood tests, to find or to help to find the cause of your symptoms.

Eating Disorder

Any psychological disorder such as anorexia nervosa or bulimia that involves insufficient or excessive food intake.

Emergency

Constitutes the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

Excess

The amount of money shown on the insured's certificate of insurance which you have agreed to pay towards the cost of eligible treatment each policy year.

Experimental treatment

A diagnostic, medical or surgical procedure, treatment or drug therapy that is considered experimental or unproven based on generally accepted medical practice.

Home country

The country for which the insured person holds a current passport and to which the insured person would want to be repatri-ated to.

Hospital

An establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a medical practitioner. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Hospital accommodation

A standard private or semi-private accommodation as indicated in the Table of Benefits. Deluxe, executive rooms and suites are not covered.

Hospital charges

Charges for accommodation, nursing, operating theatres, drugs, dressing, pathology, radiology and any other charges made by a hospital for treatment and within our fee schedule.

Infertility treatment

Treatment for both sexes including all invasive investigative procedures necessary to establish the cause for infertility such as hysterosalpingogram, laparoscopy or hysteroscopy.

In-patient

A patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.

Insured person/member

Anyone of the individuals specified on the certificate of insurance.

Local ambulance

Ambulance transport required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

Long term care

Care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long term care can be provided at home, in the community, in a hospital or in a nursing home.

Material fact

Information which is likely to influence us in the assessment, acceptance or renewal of the policy, or in making any changes to it. For example, information:

- about you or your dependants, your lifestyles, health or medical conditions, that we may have asked you questions about;
- that you have chosen to give to us; or
- that we have not asked you any questions about, but which you must disclose to us.

If you are in any doubt about whether or not a fact is material please tell us.

Medical condition

Any signs, symptom, illness, sickness, disease or injury.

Medically necessity/necessary

Services or supplies which are:

- Appropriate for the signs, symptoms, diagnosis or treatment of the medical condition.
- Provided for the diagnosis or direct care and treatment of the injury or disease.
- Within standards of good medical practice within an organised medical community.
- Not primarily for the convenience of the Insured Person or any other participating supplier providing appropriate covered services to the insured person.
- An appropriate supply and level of service needed to provide safe and adequate care.

If there is any doubt as to the medical necessity of treatment in respect of a claim, medical necessity shall be decided by our Chief Medical Officer.

Medical practitioner

A physician who is licensed to practice medicine under the law of the country in which treatment is given and where he/she is practicing within the limits of his/ her licence.

Medical practitioner fees

A non-surgical treatment performed or administered by a medical practitioner.

Midwife fees

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

The period during which we will not pay benefits for pre-existing conditions.

Newborn care

Customary examinations required to assess the integrity and basic function of the child's organs andskeletal structures. These essential examinations are carried out immediately following birth. Furtherpreventive 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 ownpolicy.

Nursing at home or in a convalescent home

Skilled nursing services given by a qualified nurse at your home. The nursing must be under the supervision of a specialist and for medical not domestic purposes

Obesity

Diagnosed when a person has a BMI (Body Mass Index) of over 30.

Oncology

Specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out treatment for cancer, from the point of diagnosis.

Oral surgical procedures

Surgical procedures, such as;

- Replantation of tooth/teeth following trauma
- Surgical removal of impacted/ buried tooth/ teeth
- Surgical removal of complicated buried roots
- Surgical drainage of dental abscess
- Apicectomy
- Enucleation of cyst of jaw
- Treatment of mandibular, zygomatic or maxillary fractures including internal or external fixation
- Excision or resection of mandible or maxilla, including removal of malignancy
- Maxillary osteotomy and prosthetic surgery
- Open operations of the jaw including the temporo-mandibular joint.
- Hospitalisation for dental treatment where anti-coagulant therapy requires management.

when carried out in a hospital by an oral or maxillofacial surgeon.

Orthodontics

The use of devices to correct malocclusion and restore the teeth to proper alignment and function.

Orthomolecular treatment

Treatment which aims to restore the optimum ecological environment for the body's cells by correcting deficiencies on the molecular level based on individual biochemistry. It uses natural substances such as vitamins, minerals, enzymes, hormones, etc.

Out-patient surgery

A surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require the patient to stay overnight out of medical necessity

Out-patient

A patient who attends a hospital, consulting room, or Out-Patient clinic and is not admitted as a Day-Patient or an In-Patient.

Palliative treatment

Any treatment given for the sole purpose of relieving symptoms rather than attempting cure of a medical condition.

Patient

The insured person being treated a medical condition.

Periodontics

Dental treatment related to gum disease.

Phobia

A persistent, irrational, intense fear of a specific object, activity or situation.

Policy

The application form, declaration, policy document, reasonable and customary fees, certificate of insurance, table of benefits, definitions, and any endorsements.

Policy period

The period between the commencement date and the expiry date shown on the Certificate of Insurance.

Post-natal care

Routine post-partum medical care to be received by the mother up to six weeks after delivery.

Pre-authorisation

A process through which an insured person seeks approval from us prior to undertaking treatment or incurring costs. If pre-authorisation is not obtained we will only cover 50% of the costs that would have been agreed if the correct procedure had been taken.

Pre-existing conditions

Any disease, illness or injury for which:

- You have received medication, advice or treatment; or
- You have experienced symptoms;

Whether the condition has been diagnosed or not in the two years before the start of your cover. Refer to the underwriting section for full details.

Pregnancy

The period of time, from the date of the first diagnosis, until delivery.

Premiums

The amount you must pay us each year as a premium for the policy and this will include insurance premium tax (IPT) dependant on the local legislation.

Pre-natal care

Common screening and follow-up tests, as required during a pregnancy. For women aged 35 and over, this includes Triple/ Bart's, Quadruple or Spina Bifida tests, amniocentesis and DNA-analysis, if directly linked to an eligible amniocentesis.

Prescribed medical aids/appliances

Any instrument, apparatus or device which is medically prescribed as an aid to the function or capacity of the insured person, such as hearing aids, speaking aids (electronic larynx), crutches or wheelchairs, orthopaedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings as well as orthopaedic arch-supports. Costs for medical aids that form part of palliative treatment or long term care are not covered. The word medical aids is not used combined, but medical appliances is, so have added in term appliance.

Prescription drugs and medicines

A chemical substance licensed as a medicine, which require a prescription for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescription drugs must be clinically proven to be effective and recognised by the pharmaceutical regulator in a given country.

Preventive treatment

Treatment that is undertaken without any clinical symptoms being present at the time of treatment. An example of such treatment is the removal of a pre-cancerous growth (e.g. mole on the skin).

Principal country of residence

The country where you and your dependants live for more than six months of the year.

Professional Sport

Professional sporting activities of any kind where a fee is received.

Psychiatry and Psychotherapy

Treatment of a mental, nervous or eating disorder carried out by a clinical psychiatrist or clinical psychologist. The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not merely an expected response to a particular event such as bereavement, relationship or academic problems and acculturation. The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Diseases (ICD-10).

Reasonable and customary

What we consider to be acceptable treatment charges based on our experience and knowledge.

Rehabilitation

Treatment aimed at the restoration of a normal form and/or function after an acute illness or injury. The rehabilitation benefit is payable only for treatment that starts immediately after the acute medical treatment ceases. Treatment must take place in a licensed rehabilitation facility.

Related medical condition

Any medical condition, which is medically considered to be associated with another medical condition.

Routine health checks

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).

Specialist

A qualified and licensed medical physician possessing the necessary additional qualifications and expertise to practice as a recognised specialist of diagnostic techniques, treatment and prevention in a particular field of medicine. This benefit does not include cover for psychiatrist or psychologist fees. Where covered, a separate benefit for psychiatry and psychotherapy will appear in the Table of Benefits.

Specialist fees

Non-surgical treatment performed or administered by a Specialist.

Speech therapy

Treatment carried out by a qualified speech therapist to treat diagnosed physical impairments, including but not limited to nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

Surgical appliances and prostheses

Artificial body parts or devices, which are an integral part of a surgical procedure or part of any medically necessary treatment following surgery.

Table of Benefits

This indicates the benefits available to you and is included with your certificate of insurance.

Therapist

A chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the law of the country in which treatment is being given.

Third party opinion

Obtaining an alternative opinion of a medical condition from a second Specialist chosen by us.

Treatment

Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.

Underwriter

As shown on the Certificate of Insurance.

Vaccinations

All basic immunisations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis. The cost of consultation for administering the vaccine as well as the cost of the drug is covered.

Waiting period

A period of time commencing on your policy start date (or effective date if you are a dependant), during which you are not entitled to cover for particular benefits. Your table of benefits will indicate which benefits are subject to waiting periods.

We/Our/Us

The Appointed agents (VfA-International) acting on behalf of the underwriter.

You/Your

The Policyholder and each Insured Person who is listed on the Certificate of Insurance.

12. Contact details

Contact us

VfA-International GbR | Gutenbergstraße 3 | 23611 Bad Schwartau | Deutschland

+49(0)451-70 73 67 12
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www.vfa-international.de