Terms Explained

PHC - Your healthcare cover partner

October 2025

Understanding your healthcare cover

Private Medical Insurance (PMI) is designed to give you reassurance by offering access to eligible private health treatment; from seeing a specialist for diagnosis to receiving the appropriate care during a stay in hospital. These, plus flexible appointment times and a large choice of private hospitals, are just some of the benefits of private healthcare cover. All helping to keep you at work and enabling you to live life well. With the current challenges facing the NHS and access to its services, private healthcare cover works to complement the care available to you through the NHS.

At PHC we pride ourselves on supporting you so you can live the happiest, healthiest life possible. The part we play is to provide a truly personal healthcare insurance service.

We appreciate it might be tricky to understand the insurance terms that appear in your communications and documentation. It's not surprising, as the language used in our insurance industry can be heavy with technical terms.

That is why we have put together this guide to help you understand your cover and make the most of it with detailed explanations, including examples, of some of the terms used.

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Glossary

Private health insurance is an insurance policy that helps cover the costs of private healthcare, including diagnostic tests and surgery. The purpose of it is to help you pay for eligible private medical treatment and care of unexpected illness and conditions that respond quickly to treatment (**acute conditions**). This means that it may not cover you for treatment of conditions that are likely to last a long time or come back (**chronic conditions**).

Eligible treatment is treatment of a medical condition that is covered by the plan and is not excluded by any of the rules in the membership handbook.

To help you understand the difference, here is how we define both types of conditions when working out whether or not your claim is eligible for cover:

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

Chronic condition - A disease, illness or injury that has one or more of these characteristics:

- It needs ongoing or long-term monitoring though consultations, examinations, check-ups 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.

Private health insurance will, in general, cover you for eligible **in-patient**, **day-patient** and **out-patient treatment**:

In-patient treatment - You stay in hospital overnight or for several nights.

Day-patient treatment - You need a medical professional looking after you as you recover from your test or treatment. You might have tests where you need sedation or other preparation for the test. For example, camera tests to look inside your body. You may be ‘admitted’ to hospital.

Out-patient treatment - You go to hospital for a consultation, tests or treatment and leave again straight after your appointment. You don’t need to recover with a medical professional looking after you.

As private health insurance is usually designed to cover treatment of new medical conditions that begin after you join, it doesn't cover for treatment of conditions you were aware of or had already had when you joined (**pre-existing conditions**). This does depend on the type of cover chosen and previous medical history when joining:

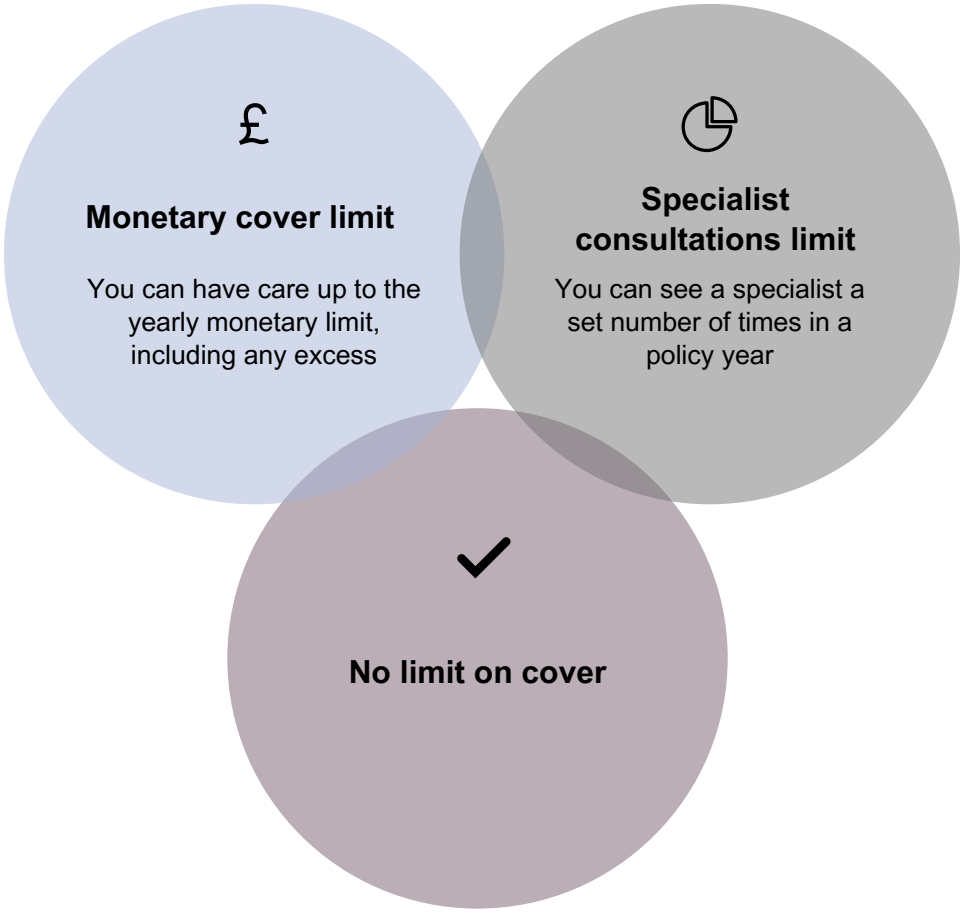
Pre-existing condition - Any disease, illness or injury that:

- you have received medication, advice or treatment in the five years before the start of your cover, or
- you have experienced symptoms of in the five years before the start of your cover, whether or not the condition was diagnosed.

What's covered and cover limits

What cover do I have with my policy?

The levels of cover you have on your plan will depend on how your plan is set up. You may have:



You'll find more information about any limits or rules in your membership handbook.

When you contact us to tell us you're having treatment, we'll tell you:

If the treatment is eligible under your cover.

If the treatment will come out of your monetary or specialist consultations limit.

What's left from your monetary or specialist consultations limit.

If any excess applies.

How do the different limits work?

£ Monetary limit

How the limit is applied
- The limit is per person, per policy year.

For example
- With an out-patient limit of £1,500, you could have:
  - A specialist consultation to discuss symptoms
  - Some blood tests
  - A follow-up consultation to discuss results
- So long as this all adds up to less than £1,500, and is covered by your plan, we'll cover the costs.

Don't forget

Some out-patient tests or treatments, including blood tests, can be expensive. Please check the cost of treatment with your specialist or hospital beforehand to make sure there's enough left from your monetary limit to pay for the treatment.

Specialist consultations limit

How the limit is applied
- The limit is per person, per policy year.

For example
- With a limit of three consultations, you could have:
  - A **first consultation** to discuss your symptoms
  - An MRI test and some blood tests
  - A **second consultation** to discuss the results
  - An operation (if your policy covers this)
  - A **follow-up third consultation** after the operation.

Don't forget

If you need more specialist consultations than your limit, you'll need to pay for these yourself, or arrange them through the NHS.

How do limits work with my excess?

If there's an excess or similar contribution on your plan, you'll need to pay it on the first invoice we receive for your out-patient treatment.

Here's an example of how it works:
- Rhea has an out-patient limit of £1,500 and an excess of £500.
- Rhea's first treatment this year costs £1,200. She pays £500 of this, because she has to pay her excess.
- However, we still need to take £1,200 off her out-patient limit, even though she paid her excess towards the treatment. This is because we take the treatment cost off the limit, regardless of who paid for the treatment.

We take £1,200 off Rhea's limit, even though she paid her excess.

This is because we take the treatment cost off the limit, regardless of who paid for the treatment.

What am I covered for?

What you're covered for will depend on how your plan is set up.

This is an example of how plans may differ and will impact what you are covered for:

Plan A

Out-patient consultations

In-patient treatment

On this plan

- You can see a specialist we recognise for an out-patient consultation
- You can have private in-patient treatment, such as surgery, at a hospital in our directory

Plan B

Out-patient consultations

In-patient treatment

On this plan

- You can't see a specialist privately as an out-patient - you will need to pay for this yourself, or use the NHS
- You can have private in-patient treatment, such as surgery, at a hospital in our directory

Please check your handbook and membership documents to see what you're covered for.

Then, get in touch with us. We'll check your plan and tell you if the condition is covered or if there are any limits on how many consultations or treatments you can have.

What am I not covered for?

Depending on your plan, we don't usually cover:

- Pre-existing conditions
  Unless your membership documents specifically say you're covered, we don't cover conditions you had before your policy started.
- Chronic conditions
- Treatment that could be carried out by a GP or in another primary care setting, such as nurses based in a GP surgery.
- Any of the conditions, treatments or other things your handbook says we don't cover.

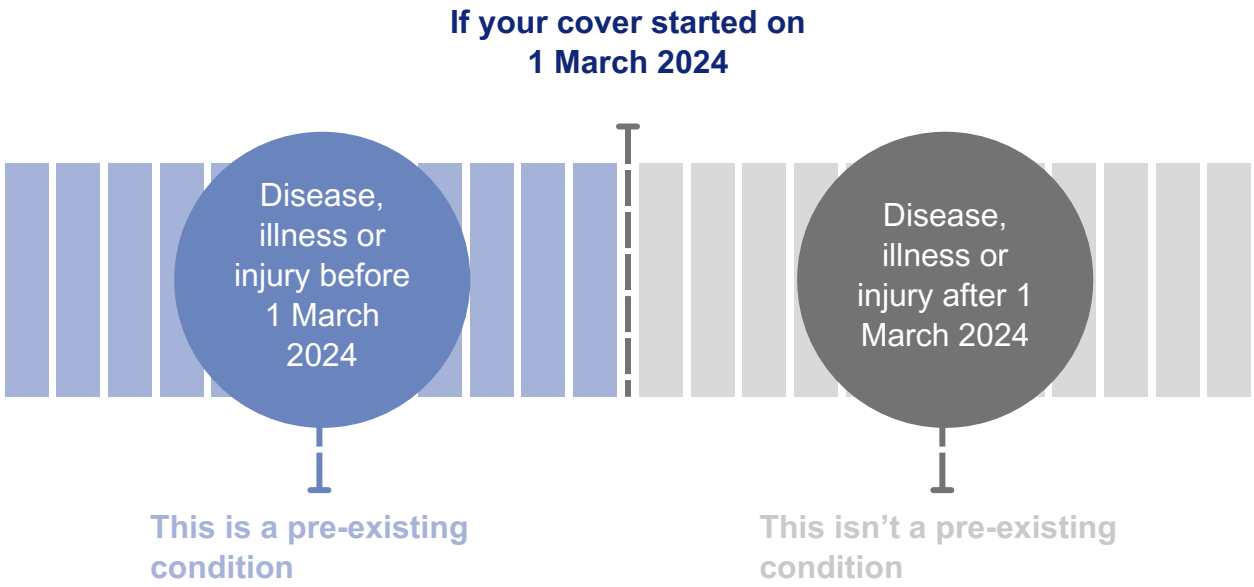
There may be other things your plan doesn't cover that are specific to you and your plan. You'll find details of these in your membership documents. You can give us a call if you're in any doubt.

Pre-existing conditions

What is a pre-existing condition?

A pre-existing condition is any disease, illness or injury you had symptoms of before your cover started. It doesn't matter if the condition was diagnosed or not.

For example: if your cover started on 1 March 2024, any disease, illness or injury you had symptoms of before 1 March 2024 is a pre-existing condition.



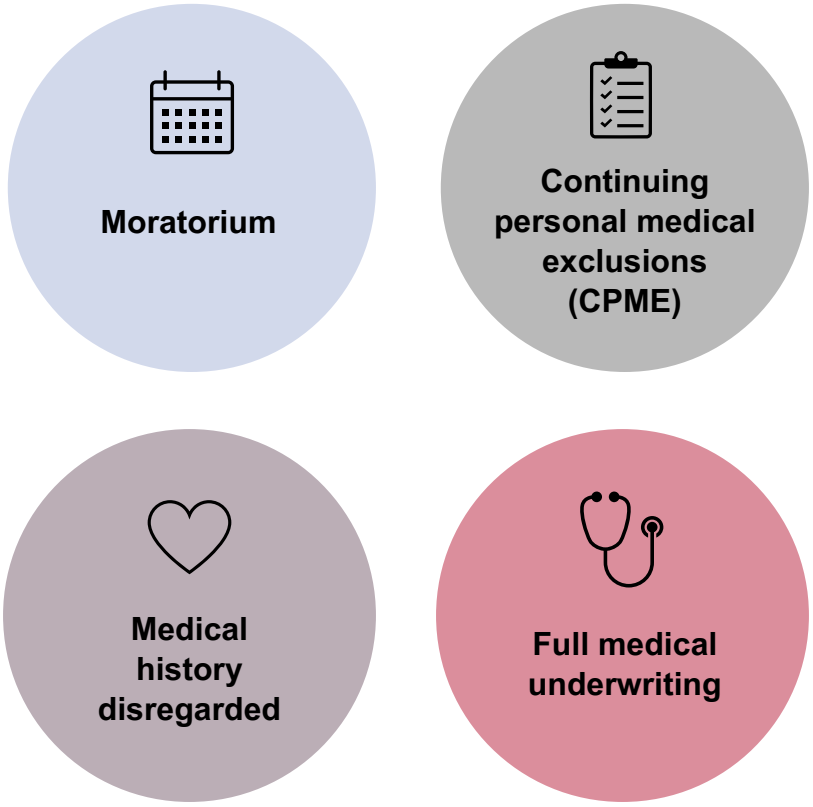
Pre-existing conditions include:

- Any condition you've taken medication for - that includes any medicine you've bought in a shop, such as painkillers.
- Any condition you've seen a GP or other medical practitioner about.
- Any condition you've had any symptoms of - even if you didn't see anyone about the symptoms.

Am I covered for pre-existing conditions?

Most health insurance plans cover you for new and unexpected medical issues, so cover for conditions that started before you joined us is limited, even if they weren't diagnosed.

There are a few ways we deal with pre-existing conditions. You might see them referred to in your membership documents or on your underwriting terms:



We told you which of these applied to you when you joined us. There's more information on the following pages.

If you need treatment, we may need to ask your doctor for more information about your condition, including when it began. We'll always ask for your consent before we do this.

Sometimes your GP may charge for filling in a form
Unfortunately, your policy won't cover the cost of this.

How do I know what I'm covered for?

Check your membership documents to see if you're covered for pre-existing conditions.

If you're in any doubt at all, we can check for you. Just give us a call.

What is a moratorium?

You won't have cover for treatment of medical problems you had in the five years before you joined us.

This is until:

- you've been a member for two years in a row, and
- you've been trouble-free from the conditions for a period of 24 consecutive months.

The diagrams below show how it works on a plan where we don't cover conditions you had in the five years before you joined:

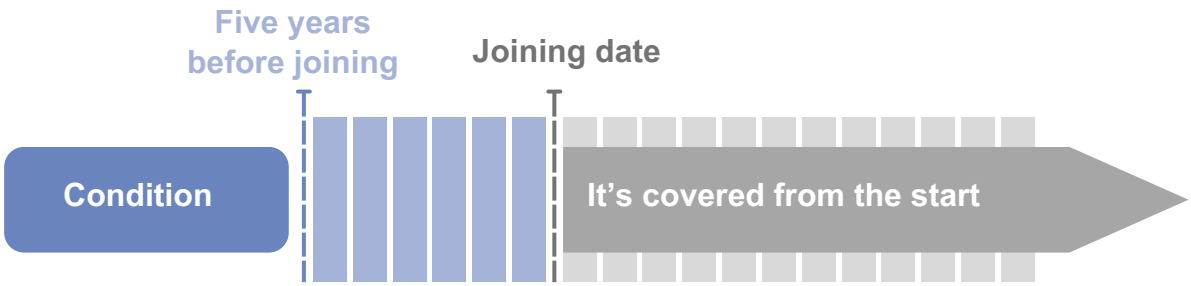
- until you've been a member for two years, and
- until you've been trouble-free from the condition for 24 consecutive months.

What do we mean by trouble-free?

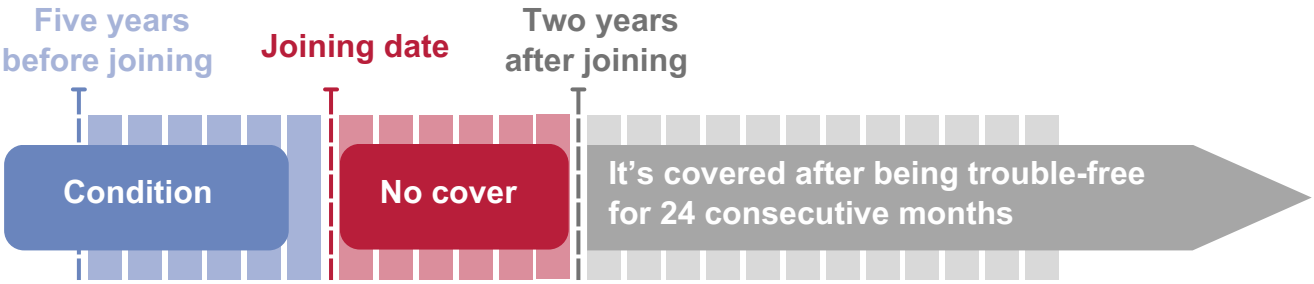
By trouble-free we mean you haven't done any of the following for this condition:

- Had advice from a medical practitioner, including a GP or specialist
- Taken medication - including over the counter drugs
- Followed a special diet
- Had medical treatment
- Received advice from a clinical practitioner, therapist or acupuncturist

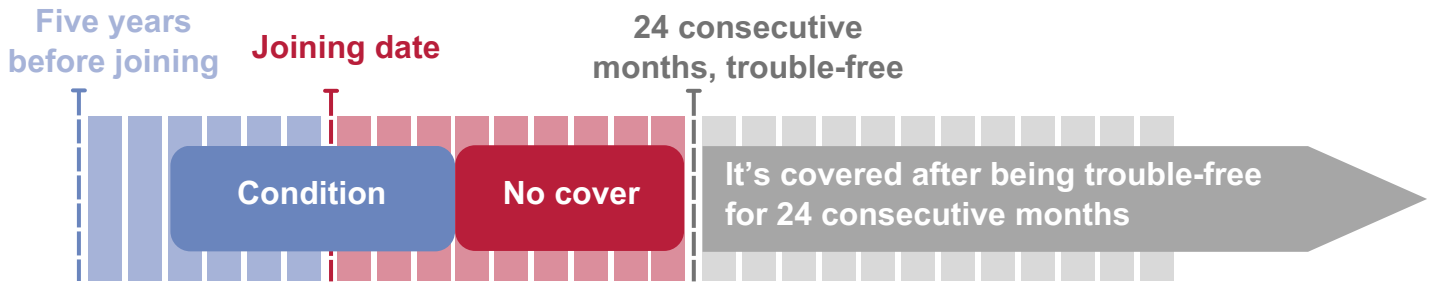
If the condition ended more than five years before you joined:



If the condition ended in the five years before you joined:



If the condition ended in the 5 years before you joined:



What is full medical underwriting?

When you joined, we asked for full details of your medical history, and we may have contacted your doctor for information.

We used this information to decide what pre-existing conditions we will and won't cover. You can find if we have applied any exclusions to your cover in your membership documents.

What are continuing personal medical exclusions (CPME)?

If you've moved to us from another healthcare insurer, we may continue to cover or exclude conditions in the same way as your previous plan. Your original moratorium start date will be used for claims assessment to ascertain whether a condition is pre-existing.

This is 'continuing personal medical exclusions'.

So, if you had treatment for a condition under your previous plan, we'll continue to cover it under your new plan. This is subject to the terms and conditions of your new plan.

If a condition was excluded with your previous insurer, we'll continue to exclude it.

What is medical history disregarded?

This is where we don't look at your medical history at all.

If you joined us on 'medical history disregarded' terms, we accepted any pre-existing conditions you might have had when you joined.

Chronic conditions

Most health insurance covers you for

Acute conditions

These are medical conditions that:

are new and unexpected

are likely to respond quickly to treatment.

The treatment will aim to return you to the same state of health you were in before having the condition.

Most health insurance is not designed to cover

Chronic conditions

These are medical conditions that:

last a long time or come back, or

need long-term control or relief, or

need long-term monitoring or rehabilitation, or

have no known cure.

You can find out more about chronic conditions on the following pages.

Do you count cancer as a chronic condition?

We treat cancer differently to other chronic conditions.

Please check your membership documents for details of how your plan covers cancer.

Do you cover any treatments for chronic conditions?

We may be able to cover:

- **Short-term treatment** if your chronic condition flares up or gets worse unexpectedly.

Please always get in touch with us before arranging any treatment so we can check what your policy covers.

We won't usually cover:

- Routine follow-up consultations for chronic conditions, unless you're on a plan that includes this cover.
- Monitoring a medical condition, unless you're on a plan that includes this cover.
- Treatments that only offer temporary relief from symptoms and don't deal with the condition itself.

How do I know if my condition is a chronic condition?

When you need treatment, get in touch with us first.

If we think your condition is chronic, we'll tell you, and explain what your policy covers and doesn't cover.

We might ask your permission to contact your GP or specialist to confirm diagnosis, treatment and how they think your condition will progress.

What happens if I've been having treatment for a chronic condition?

If your GP or specialist confirms you have a chronic condition, we'll tell you when we'll stop covering the condition.

You'll then need to either pay for treatment yourself or have the treatment on the NHS.

We'll contact you in plenty of time so that you can talk to your GP or specialist about your options.

Why we ask for more information

Why do you ask my doctor for information?

We sometimes ask your GP or specialist for more information about your medical condition or treatment

This is so that we can make sure your policy covers the condition, and tell you about anything that we can't cover. If you've used our online GP service, we may still need to ask for this information from your registered GP, as they have access to all your medical records.

We might ask for more information to...

You can find out more about these on the following page.

Tell me more about why you...

Ask about pre-existing conditions

With many of our plans, cover for conditions that started before you joined (pre-existing conditions) is limited.

We may ask for more information to check when your condition or symptoms started, and whether they were pre-existing.

Ask about planned or pending treatment

Your policy doesn't usually cover anything already planned or pending when you joined. This includes treatments, consultations, investigations and diagnostic tests.

We may ask for more information to check if your treatment was already planned or pending when your plan started.

Ask my GP or specialist for further information

Many of our plans don't cover tests or treatment you could have in a primary care setting – such as at your GP surgery.

We may ask for information to understand why your GP has referred you to a specialist or hospital. Sometimes your GP may charge for filling in a form - unfortunately, your policy does not cover the cost of this.

We may also need further information from your specialist in order to assess the ongoing eligibility of your claim.

Do I need to give my consent?

If we need to request information from your doctor, we'll always ask for your consent first. You'll need to sign a form or fill it in online.

We'll tell you why we're asking, and what information we're asking for.

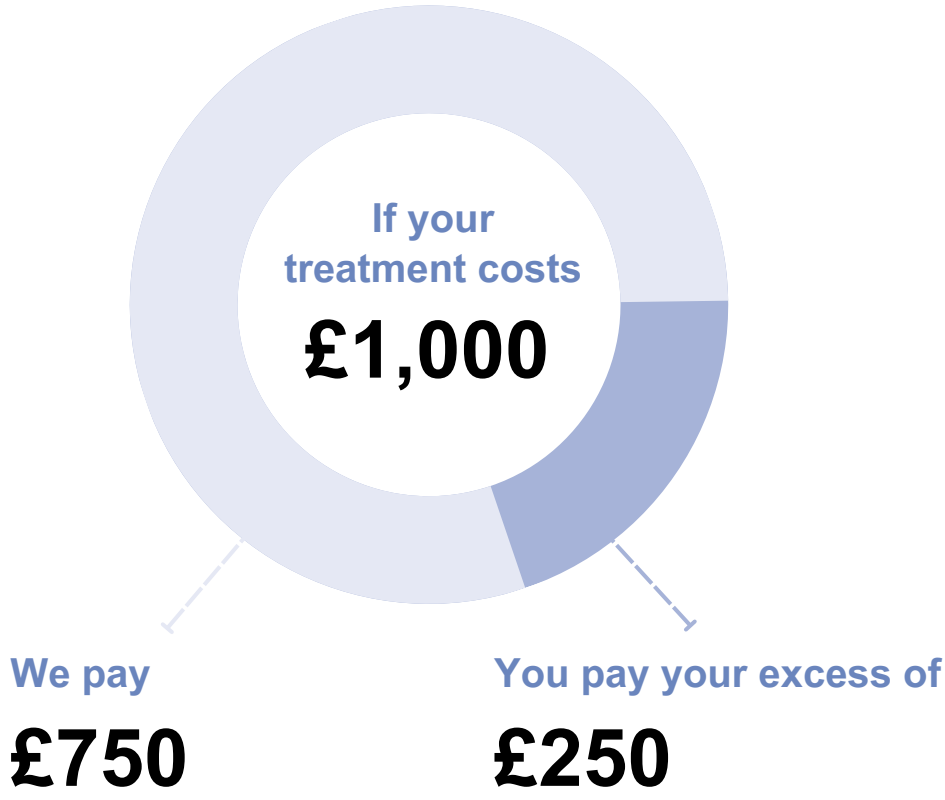
If you don't give us your consent, or provide us with the information we've asked for, we may not be able to proceed with your claim.
We'll let you know if this happens, and explain your options.

Excess

What is an excess?

An excess is the amount that needs to be paid each policy year towards the cost of treatment, if you make a claim.

For example: if your treatment costs £1,000 and you have an excess of £250, we'll pay £750 and you'll pay £250.



If there's more than one person on your policy (for example, your partner or child), each person will have their own excess.

So, if there are two people on your policy and you both claim, you'll have to pay two excesses - one for each person.

Each person covered under your plan will have the same excess.

How does an excess work?

With an excess, you pay an amount towards the cost of treatment per policy year.

Once you've paid your total excess, you won't have to pay it again if you have more treatment in that policy year. For example;

- If you have an excess of £250 and you make a claim for £150, you'll pay £150.
- If your treatment continues and you make another claim for £200, you'll pay £100 towards the treatment, and we'll pay the £100 balance.
- As you've now paid your excess in full, you won't have to pay another excess this policy year, even if you claim for a different condition.

Good to know

The excess is per person, per policy year, not per condition.

If you claim for several conditions, you'll still only pay the same amount.

When you contact us to make a claim, we'll tell you if you need to pay an excess.

How and when do I pay my excess?

After your treatment, we'll send you a claim update with details of who to pay and how. Please don't pay anything until you get this.

The specialist, hospital or other treatment provider may contact you to ask you for your excess, but you can ignore this until you receive your claim update.

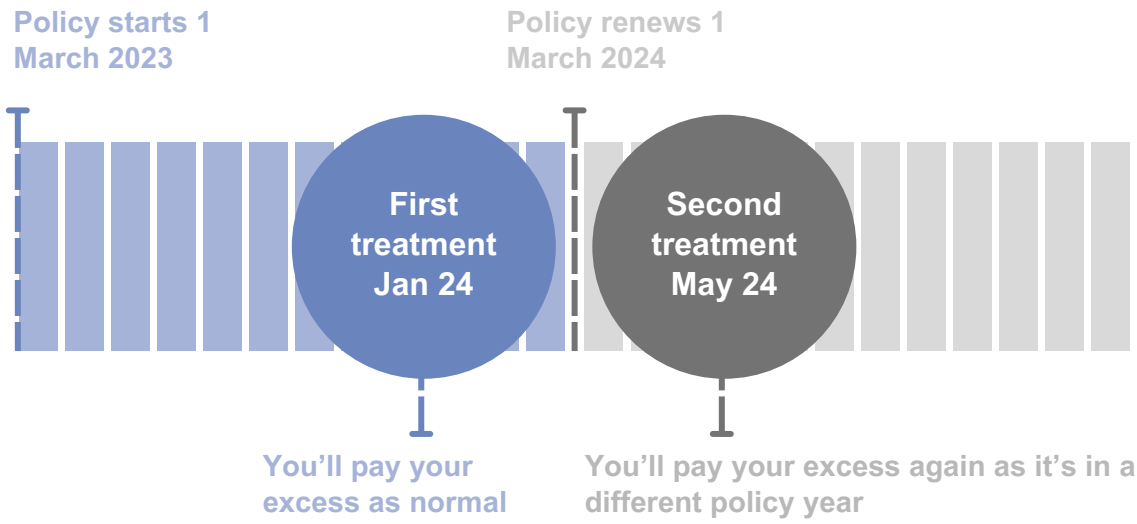
If you've already paid by the time you get your claim update, don't worry - we'll sort this out with your provider.

What if treatment continues after renewal?

If your treatment continues past your renewal date, we'll ask you to pay the excess again for any treatment that happens after you renew.

So, if your treatment straddles a new renewal date, you'll have to pay your excess twice.
For example:

- If your policy renews on 1 March and you make a claim the following January for treatment, you'll pay your excess in January.
- If you then have more treatment for the same condition in May, you'll pay your excess again, as your treatment is in two policy years.



When we ask you to pay towards treatment

Why do you ask me to pay towards treatment?

There are instances where we may ask you to make a contribution towards the cost of your treatment. These are:

1

When your plan includes an excess

You can find out more in our guide to paying an excess.

2

When there's a difference between your treatment cost and what your policy covers

If this happens, you may have to pay the difference, or a contribution towards it.

In this guide, we look at this type of payment - you can find out more on the following pages.

What is a 'shortfall'?

You'll sometimes see the word 'shortfall' used for an amount that we ask you to pay.

Why doesn't my policy cover the cost?

Typically health insurers have limits on what they'll pay. If they didn't, the cost of health insurance would be higher for everyone.

Here are the main reasons you may need to pay towards treatment:

Your choice of specialist

You may need to pay when:

- A specialist charges more than our agreed rates.
- Your plan requires you to use a specialist we've sourced, or a hospital on a particular list, but you want to use a different specialist or hospital.

When you contact us we'll tell you if this is the case, and you'll have the chance to switch to a different specialist or hospital.

For more details, see 'Costs to do with your choice of specialist' on the next page.

You've used up a limit

You may need to pay when you have a yearly limit - for example an out-patient limit or specialist consultations limit - and you've used this up.

For more details, see 'Costs if you've used up a limit' on the next page.

The type of treatment

You may need to pay when your policy doesn't cover a specific treatment, or there's a limit on how much we'll pay for the treatment.

In some cases, you'll need to pay the full cost of this yourself, or transfer to the NHS. In other cases, we may make a contribution toward the treatment and you'll need to pay the rest.

For more details, see 'Costs to do with the type of treatment' on the next page.

Always contact us before your treatment so we can check if we'll pay in full

If you contact us before each stage of your treatment, we'll check if your policy covers the treatment in full.

If we don't cover them in full, we'll let you know and talk you through your options.

Costs to do with your choice of specialist

If you need to see a specialist, it's easiest if you ask the GP for an 'open referral'.

This doesn't name a particular specialist, and it means we can source one for you whose fees we cover in full.

Before you arrange any treatment, please always get in touch.

When you contact us:

- We'll either source a fully qualified specialist for you, or tell you if your policy covers your chosen specialist's fees in full.
- If the specialist's fees aren't covered in full, we'll explain how much you may need to pay. We'll also offer to source a specialist whose fees we'll cover in full.

Costs if you've used up a limit

On some plans, you'll have a limit on how much treatment we'll pay for.

For example, we may pay for out-patient treatment up to £1,000 a year.

Once you've used up this limit:

- You can still have the treatment privately, but you'll need to pay for it yourself.
- Or you can have the treatment on the NHS, if appropriate.

When you contact us about your treatment, we'll tell you how much of your limit is left.

We base this on the invoices we've received so far. If you're close to the limit, please contact your specialist or hospital and ask for an estimate of how much the treatment will cost. This will then give you an idea of whether you'll need to pay towards it. Your limit will reset at renewal.

Costs to do with the type of treatment

Here are the situations when you may need to pay towards a specific treatment:

With some plans, we only pay up to a set limit for some treatment. This limit could be:

- sessions (for example, 10 sessions)
- money (for example, up to £5,000).

If your treatment goes over this limit, you'll have to pay the difference in costs.

You can find more information about how we cover specific treatments in your handbook.

How will I know if I'll have to pay anything?

When you contact us about your treatment, we'll tell you if there's anything to pay.

We'll explain why you need to pay, and who to pay. We'll also send you a claim update after your treatment that explains this.

Need some more help?

Understanding the language can be tricky, so if you need help, give us a call.

You'll receive information about what you're covered for and how your policy works in your membership documents.

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