Private Medical Insurance

Corporate Healthcover4*life*

Specified Hospital List Option

Handbook

October 2019

PHC

A member of the global AXA group.

Claims line

0800 068 7111

Monday to Friday 8am to 8pm and Saturday 9am to 5pm

24 hour medical help and information

Talk to a medical professional at any time, day or night

0800 027 1393

Leaving your group

Stay covered with the same personal medical underwriting

Call us on 0800 533 5962

Monday to Friday 8am to 8pm and Saturday 9am to 1pm

If you would like to receive this handbook or any other of our literature in a large print, audio (CD or tape) or Braille format, please contact us.

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1 Quick-start guide to your membership

This section explains the basics of the cover your **group** has chosen. It also tells you some of the key things that are not covered too.

Reading this section will help you to understand the rest of the information in the handbook.

The tables in this section only give you an outline of your cover. For full details of your cover, please read the rest of your handbook too.

Cover is provided under a **group insurance contract** provided to the **group**, who is the policyholder. The **group** has chosen this **plan** to provide cover for its members or employees.

Lead members covered under the **group insurance contract** are entitled to the benefits as set out within this handbook, subject to receipt of the premium from the **group**.

You do not have legal rights under the **group insurance contract** as the contract is with the **group**. Renewal of your cover under the **group insurance contract** is dependent on the **group** renewing the **group insurance contract** and your cover under that contract.

If you have any questions about your membership to the **plan** or want to make any changes such as adding a **family member** or ending your cover under the **plan** please contact your group administrator.

1.1 > Your core cover – applies to all members

1.2 > The main things we don't cover

1.3 > Expert Help

1.4 > Counselling and Support Service

Words and phrases in bold type

Some of the words and phrases we use in this handbook have a specific meaning. For example, when we talk about **treatment**.

We've highlighted these words in **bold**. You can find their meanings in the glossary or in the section they apply to.

You and your

When we use you and your, we mean the **lead member** and any **family members** covered by your **plan**.

We, us and our

When we use we, us or our, we mean the Permanent Health Company (PHC) on behalf of AXA PPP healthcare, who is the insurance company who underwrite this product.

1.1 > Your cover

This benefit table shows you the cover your membership gives you.

Benefit Table for HealthCover4*life*		
If you're an **in-patient** or **day-patient**		
Private hospital and **day-patient unit** fees	✓ Paid in full so long as you use a hospital or **day-patient unit** in our **Specified Hospital List**	Including fees for **in-patient** or **day-patient**: ▪ accommodation ▪ **diagnostic tests** ▪ using the operating theatre ▪ nursing care ▪ drugs ▪ dressings ▪ physiotherapy ▪ surgical appliances that the specialist uses during surgery. » For details, see 3.7
Cash payment if you use a hospital or **day-patient unit** that is not in our **Specified Hospital List**	✓ £50 a night for **in-patient treatment** ✓ £50 a day for **day-patient treatment**	If you have private **in-patient treatment** or **day-patient treatment** at a private hospital or **day-patient unit** that is not in our **Specified Hospital List**. » For details, see 3.7
Specialist fees	✓ No yearly limit	Includes fees for: ▪ surgeons ▪ anaesthetists ▪ physicians. » For details, see 3.6
Private hospital and day-patient unit fees for psychiatric **treatment**.	✓ Plan 1: up to 45 days a **year**. ✓ Plan 2: up to 28 days a **year**. ✓ Plan 3: up to 28 days a **year**. × Plan 4: no cover	So long as you use a hospital or **day-patient unit** in our **Specified Hospital List**. Including fees for: ▪ accommodation ▪ **diagnostic tests** ▪ drugs. » For details, see 3.7

Benefit Table for HealthCover4*life*		
Accommodation for one parent while a child is in hospital	✓ Paid in full	Covers the cost of one parent staying in hospital with a child under 16. The child must be covered by your membership and having **treatment** covered by it.
Hotel accommodation for one parent while a child is in hospital	✓ Up to £100 a night up to £500 a **year**	Covers towards the costs for one parent to stay near to the **specified hospital** where a child under 16 is having **treatment**. The child must be covered by the membership and having **treatment** covered by it. We will not take any excess off this cash payment.
If you're an **out-patient**		
Surgery	✓ No yearly limit	» For details, see 3.3
CT, MRI or PET scans	✓ Paid in full at a **scanning centre**, or hospital listed as a **scanning centre**, in our **Specified Hospital List**	A **specialist** must refer you. CT = Computerised Tomography MRI = Magnetic Resonance Imaging PET = Positron Emission Tomography » For details, see 3.7
Specialist consultations and **practitioner** fees when your **specialist** refers you.	✓ Plan 1: no yearly limit ✓ Plan 2: no yearly limit ✓ Plan 3: no yearly limit ✓ Plan 4: two **specialist** consultations a **year**.	This benefit does not include **specialist** consultations or **practitioner** fees for psychiatric illness.
Diagnostic tests performed by your **specialist** or when your **specialist** refers you.	✓ No yearly limit	

Benefit Table for HealthCover4*life*

The following four benefits have a combined overall yearly limit of: Plan 1: No yearly limit Plan 2: £1,500 a **year** Plan 3: £1,000 a **year** Plan 4: £500 a **year**		
Fees for **out-patient treatment** by **physiotherapists**.		Within these limits when your **GP** refers you or when you have **physiotherapist** or **therapist treatment** through our Working Body team **treatment** can include: Plan 1: ▪ up to an overall maximum of 20 sessions in a **year** with a **physiotherapist** and up to 20 sessions in a **year** with a **therapist**, **acupuncturist** or **homeopath**; Plan 2, Plan 3, Plan 4: ▪ up to an overall maximum of 10 sessions in a **year** with a **physiotherapist** and up to 10 sessions in a **year** with a **therapist**, **acupuncturist** or **homeopath**; and for all Plans: ▪ further sessions (as long as we or our Working Body team agree them first) when your **specialist** refers you.
Fees for **out-patient treatment** by **therapists**, **acupuncturists** or **homeopaths**.		
Specialist consultations for psychiatric illness	× Plan 4: No cover	
Psychiatric **treatment** by psychologists or psychotherapists	× Plan 4: No cover	

Other benefits		
Cash payment when you have free **treatment** under the NHS	✓ Plan 1: £200 a night up to £6,000 a **year**. ✓ Plan 2: £100 a night up to £2,000 a **year**. ✓ Plan 3: £100 a night up to £2,000 a **year**. ✓ Plan 4: £100 a night up to £2,000 a **year**.	We pay this when: ▪ you are admitted for **in-patient treatment** before midnight; and ▪ we would have covered your **treatment** if you had had it privately. You can also receive this cash payment if you have **treatment** in an NHS Intensive Therapy or Intensive Care unit, whether it follows private **treatment** or not. If you have an excess, we will not take this off this cash payment.
Cash payment when you have free **day-patient treatment** under the NHS	✓ Plan 1: £150 per claim. ✓ Plan 2: £50 per claim. ✓ Plan 3: £50 per claim. ✓ Plan 4: £50 per claim.	We pay this when: ▪ we would have covered your treatment if you had had it privately.
Cash payment if you have chemotherapy or radiotherapy free on the NHS	✓ Plan 1: £50 a day up to £2,000 a **year.** ✓ Plan 2: £50 a day up to £2,000 a **year.** ✓ Plan 3: £50 a day up to £2,000 a **year.** × Plan 4: no cover.	If you choose to have **day-patient** or **out- patient** chemotherapy or radiotherapy to treat **cancer** on the NHS. We will only pay this if the **treatment** would have been covered by your membership. If you have an excess, we will not take this off this cash payment. » For details, see 4.1
External prosthesis	✓ Up to £5,000 for the lifetime of your membership	We will pay this benefit towards the cost of providing an **external prosthesis**. If you have an excess, we will not take this off this cash payment. » For details, see 4.10
Childbirth benefit	✓ Plan 1: £200 for each birth. ✓ Plan 2: £100 for each birth. ✓ Plan 3: £100 for each birth. × Plan 4 – No cover.	For each birth which takes place after one of the parents named on the birth certificate has been covered on the **plan** for 10 or more months in a row.

Ambulance transport	✓ Plan 1: Paid in full ✓ Plan 2: £250 a **year**. ✓ Plan 3: £250 a **year**. ✗ Plan 4: No cover.	If you are having private **in-patient** or **day-patient treatment** and it is medically necessary to use a road ambulance to transport you to another medical facility.
Nurse to give you chemotherapy or antibiotics by intravenous drip at home	✓ Paid in full	We will pay for **treatment**: ▪ at home or ▪ somewhere else that is appropriate. We will pay for a **nurse** to give you the following by intravenous drip: ▪ chemotherapy to treat cancer ▪ antibiotics. This is so long as: ▪ we have agreed the **treatment** beforehand; and ▪ you would otherwise need to be admitted for **in-patient** or **day-patient treatment**; and ▪ the nurse is working under the supervision of a recognised **specialist** – see section 3; and ▪ the **treatment** is provided through a healthcare services supplier that we have a contract with for this kind of service.
Home nursing	✓ Plan 1: No yearly limit. ✓ Plan 2: No yearly limit. ✓ Plan 2: No yearly limit. ✗ Plan 4: No cover.	We will pay for the fees for a qualified **nurse** when: ▪ nursing is provided under the direction of the treating **specialist** for medical reasons; and ▪ it immediately follows **in-patient** or **day-patient treatment**.

Hospice cash benefit	✓ Plan 1: £75 a day up to a maximum of 15 days for the lifetime of your membership. ✓ Plan 2: £75 a day up to a maximum of 15 days for the lifetime of your membership. ✓ Plan 3: £75 a day up to a maximum of 15 days for the lifetime of your membership. × Plan 4: No cover.	We will pay this when you are at the terminal stage of **cancer**.
Hospice donation	✓ Plan 1: £75 a day up to a maximum of 15 days for the lifetime of your membership. ✓ Plan 2: £75 a day up to a maximum of 15 days for the lifetime of your membership. ✓ Plan 3: £75 a day up to a maximum of 15 days for the lifetime of your membership. × Plan 4: No cover.	We will pay a charitable donation to a hospice providing care in the terminal stage of **cancer**.
Recuperative care. This is to cover the services of: (i) a **nurse** for secondary nursing care; or (ii) a **care assistant** for the following personal care services: Household duties • washing • cooking • cleaning • general household	✓ Plan 1: up to a maximum of £500 a **year**. × Plan 2: No cover. × Plan 3: No cover. × Plan 4: No cover.	We will pay when the recuperative care: ▪ is received in the 90 days after your date of discharge following in-patient treatment that the plan covers; and ▪ is certified by your GP or specialist as being necessary because of your medical or domestic circumstances; and ▪ if the claim is for household these tasks would normally be carried out by the person claiming the benefit.

chores • shopping • preparing meals. Help with personal hygiene • washing and bathing • eating and drinking • dressing and undressing • using the toilet.		

1.2 > The main things we don't cover

Like all health insurance plans, there are a few things that are not covered. We've listed the most significant things here, but please also see the detail later in your handbook.

Does my membership mean I don't need to use the NHS?

No. Your insurance is not designed to cover every situation. It is designed to add to, not replace, the NHS. There are some conditions and treatments that the NHS is best at handling – emergencies are a good example.

What are the key things my membership doesn't cover?

Your plan does not cover	For more information	Notes
Pregnancy and childbirth	» For details, see 4.24 or call us on 0800 068 7111	Few health insurance plans cover pregnancy and childbirth because they are not illnesses, and the NHS is set up to deal with them.
Treatment of **medical conditions** you had, or had symptoms of, before you joined.	» For details, see 3.4	Your **plan** is designed to cover necessary **treatment** of new **medical conditions** that arise after you join.
Treatment of ongoing, recurrent and long-term conditions (**chronic conditions**)	» For details, see 3.5	
Fees if you choose to use a hospital that is not in our **Specified Hospital List**	» For details, see 3.7	If you choose to use a different hospital for private treatment that would have been covered by your plan, we may pay you a small cash payment. We use a **Specified Hospital List** as it helps us to keep subscriptions affordable. » See our **Specified Hospital List**
Plan 1a, Plan 2a, Plan 3a, Plan 3b and Plan 4 members: Psychiatric **treatment**	» For details, see 4.20	
Dental **treatment**	» For details see 4.32	

Your plan does not cover	For more information	Notes
Plan 3b members: **Treatment** that the NHS can give you within six weeks of when you need it	» For details see 3.8	As you have the NHS six week option, if the NHS can give you the hospital **treatment** you need within six weeks of when you need it, you'll need to use the NHS. If you are having **out-patient treatment** that is covered by the **plan** there are some exceptions where you can go private straight away. See 3.8 for more information.

1.4 > Expert Help

Have you ever wished a friend or someone in your family was a medical expert? You'd be able to talk to them whenever you liked and they'd have time to listen, reassure and explain in words you understand.

Being there to help with your health questions is just what our Expert Help services are here for. Our medical teams including nurses and a wide variety of healthcare professionals can answer the questions you might often wish you could ask.

Our Expert Help services do not diagnose or prescribe, and are not designed to replace your GP. Any information you share with us is confidential and will not be shared with other parts of our business, like our claims department.

Call with your health queries any time – just ask

Our medical team is ready to help whether you want to talk about a specific health worry, medication and treatment or simply need a little guidance and reassurance.

You can speak to them whenever you want to – day or night.

Health at Hand

0800 027 1393

24 hours a day, 365 days a year.

Midwife and pharmacist services – Monday to Friday 8am to 8pm, Saturday 8am to 4pm and Sundays 8am to 12pm.

The experts

- nurses
- counsellors
- midwives
- pharmacists.

Health Information you can trust

Our online Health Centres bring together the latest information from our own experts, specialist organisations and NHS resources.

You can also put your own questions to our panel of experts at our regular live online discussions.

Alternatively you can e-mail your question through our Ask the Expert online panel and an appropriate medical professional will respond to you.

Visit our website

axappphealthcare.co.uk/health

The experts

- Extensive panel, including doctors, psychologists, nurses, physiotherapists and dieticians.

Support from our Dedicated Nurse Service

Our members have access to our Dedicated Nurse service, 24/7, 365 days a year. If you are diagnosed with a heart condition or cancer, our dedicated nurses will be there for you and your family

Our claims line will put you in touch with a nurse on diagnosis. Dedicated Nurses are available 24 hours a day, 365 days a year.

The experts

- dedicated nurses.

1.5 > Counselling and Support Service

Sometimes daily life can seem full of challenges.

So it's reassuring to know you've got somewhere to turn when you need reliable information or support, and someone to talk to when things don't run as smoothly as you'd like.

As a PHC member you and your family have access to a comprehensive counselling and support service provided by AXA ICAS Limited.

If you are feeling upset, worried or stressed or have a medical concern, qualified counsellors are on hand to support you. They will help you to explore and understand your issues and provide guidance and action which could include self-help or face-to-face counselling where clinically appropriate.

Additionally the service also provides expert guidance on everyday matters such as legal and financial concerns, relationship issues and consumer rights.

Counselling and Support Service

Personal Support

Direct, confidential and unlimited 24 hour access to qualified counsellors who can provide clinical support and guidance or just an ear to listen to.

Face-to-face counselling

Up to five face-to-face sessions with all complex cases assessed and directed by fully trained psychologists, where clinically appropriate.

Counselling via email

e-counselling allowing you to access counselling discretely and confidentially at a time and place that suits you.

LifeManagement™ support

Access to support and guidance on a range of everyday matters, such as financial, legal, consumer, housing issues and family care such as childcare, eldercare and disability issues.

Online portal

A wealth of up-to-date tools, information, guidance and accessible support online 24/7.

It is a completely confidential and impartial service and you can call it as often as you need to.

To speak to someone please call

0800 316 1213

24 hours a day, 7 days a week

Access the online portal:

axabesupported.co.uk

Username: phc

Password: supported

2 Making a claim

1 Ask your GP for an open referral

If your GP says you need specialist treatment, tell them you want to go private and ask for an 'open referral'.

With an open referral your GP doesn't name a particular specialist, but instead gives you the type of specialist you need to see, for example a cardiologist. This means our Fast Track Appointments Service can help you find a suitable specialist who works from a specified hospital and make a convenient appointment for you. Occasionally the NHS will be best placed to provide care locally (for example specialist paediatric (children's) care at an NHS centre of excellence). When this is the case we will talk to you about your NHS options as well.

2 Contact us on 0800 068 7111 before you see the specialist

Contact us as soon as you've seen your GP. It's important you contact us before you see the specialist or have any treatment so that we can tell you what you're covered for. This will mean you don't end up having an unexpected bill for treatment that you're not covered for.

If your GP refers you to a named specialist, we will check that specialist is recognised. If the specialist is recognised, but doesn't work from a specified hospital we will pay their consultation fees in full. You should contact us before you have any diagnostic tests or treatment as these must take place at a specified hospital.

3 We'll check your cover and let you know what happens next

We may ask you to provide more information, for example from your GP or specialist. You, your GP or your specialist must provide us with the information we ask for by the date that we ask for it or you may not be covered for your claim.

For muscle, bone and joint pain, you can use Working Body – no GP referral needed

When you experience muscle, bone or joint pain, it's important that you get the most appropriate support early.

With 'Working Body' you can get access to advice and treatment without the need for a GP referral. As soon as you develop a problem, just call the claims line on 0800 068 7111. They'll check you're covered and refer you to the Working Body team at AXA PPP healthcare.

During your phone assessment, a physiotherapist will listen to your concerns, take you through an initial assessment and then advise the most appropriate treatment for you.

Members under the age of 18 will need a GP referral for these types of conditions as the 'Working Body' service is not available to them.

Stronger Minds – faster access to support and treatment for stress, anxiety and depression

Step 1

Call the claims line on 0800 068 7111. We will check that you are covered and pass you straight through to the Stronger Minds team or arrange for you to be called back.

Step 2

One of the counsellors or psychologists will talk things through and make an initial assessment (calls may be recorded and/or monitored for quality assurance, training and as a record of your conversation).

Step 3

Having listened to your concerns, the counsellor or psychologist will suggest a treatment plan clinically appropriate for you. This could be telephone, email or face to face counselling*, a psychiatrist or psychologist consultation or simply giving you some self-help advice.

** only counselling arranged by Stronger Minds is covered by your plan.*

The Stronger Minds team will also provide ongoing clinical case management, as required, to monitor clinical outcomes.

There is no cover for the treatment of psychiatric illness on Plan 1a, Plan 2a, Plan 3a, Plan 3b or Plan 4. You are however still entitled to receive counselling services through our Counselling and Support Services (more information on page 14)

Stronger Minds is only available to members aged 18 years or over.

For skin concerns you can use our self-referral service

If you are concerned about any marks or moles on your skin, you can call your Claims Consultants to see whether the self-referral service can help. You can choose to use the service without seeing your GP first.

Call us on 0800 068 7111 - You can call your Claims Consultants as soon as you experience problems or have any concerns. They will check your cover and take you through some questions designed to show whether the service can help.

Next steps - If your answers show the service can help and you decide to use it, we'll refer you to the service who can arrange a diagnostic appointment. We'll ask for your consent before transferring you and the service will take things from there. They will be responsible for making a diagnosis.

If the service isn't suitable for you, or you decide you'd rather not use it, it's best to make an appointment with your GP as soon as possible for further advice.

Members under the age of 18 will need a GP referral for these types of conditions as the self referral service is not available to them.

How we pay claims

We normally settle any bills directly with the **specialist** or the hospital where you've had your **treatment**. If your **treatment** is not covered for any reason, we will let you know.

How do you pay my medical bills?

Specialists and hospitals normally send their bills to us, so we can pay them directly. If you need to pay an excess, we will let you know how to pay it.

» For more details, see 5.2

Do I need to tell the place where I have my treatment that I am an AXA PPP healthcare member?

Yes you must tell the place where you have your **treatment** that you are an AXA PPP healthcare member. This will mean that the fees charged for your **treatment** are those we have agreed with the hospital or centre.

What happens if I've paid the bills myself already or if I receive a bill?

If you paid your medical bills yourself and your **treatment** is covered, we will refund you the rates we have agreed with the hospital or centre, minus any excess. Please send the original receipts and invoices from the specialist or hospital to PHC Claims Ltd, 32 Church Street, Rickmansworth, Hertfordshire, WD3 1DJ or by email to support@thephc.co.uk.

If you receive a bill, please call us and we'll explain what to do next.

What should I do if I need further treatment?

If you need further **treatment**, please call us first to confirm your cover.

The information we may need when you make a claim

When you call us, we'll explain if your **treatment** is covered and normally you won't need to fill in any forms.

However, sometimes we need more detailed medical information, including access to your medical records.

What does 'more detailed medical information' mean?

We may need more detailed information in any of the following ways:

- We may need your **GP** or **specialist** to send us more details about your **medical condition**. Your **GP** may charge you for providing this information. This charge is not covered by your **plan**.
- We may also ask you to give us consent to access your medical records.
- In some cases, we may also ask you to complete additional forms. We will need you to complete these forms as soon as possible, but no later than six months after your **treatment** (unless there is a good reason why this is not possible).
- Very rarely, we may have to ask a **specialist** to advise us on the medical facts or examine you. In these cases, we will pay for the **specialist** to do this and will take your personal circumstances into account when choosing the **specialist**.

What happens if I don't want to give the information you've asked for?

If you do not give us information we ask for, or do not consent to our accessing your medical records when we ask, we will not be able to assess your claim and so will not be able to pay it. We may also ask you to pay back any money that we have previously paid to do with this **medical condition**.

What if my treatment isn't covered?

If your membership does not cover your **treatment**, we'll explain this and also tell you about what we can do to support you through your NHS **treatment**.

What if I want to see a specific specialist?

We always recommend that you ask your **GP** for an open referral. That's a referral that does not name a specialist. With an open referral, you'll have a choice of **specialist** and we can make your appointment for you. This will also mean we can check that we cover that **specialist's** fees.

However, if you would prefer to use a specific **specialist**, or if your **GP** has already named a specialist, simply call us as soon as you can and we can tell you whether we cover that specialist's fees. If we don't, we can suggest an alternative and make the appointment for you if you wish.

Where can I find more information about the quality and cost of private treatment?

You can find independent information about the quality and costs of private treatment available from doctors and hospitals from the Private healthcare Information Network: www.phin.org.uk

What happens if I need emergency treatment?

In an emergency, please call for an NHS ambulance or go to a hospital A&E department. Most private hospitals are not set up for emergency **treatment**.

If you need further **treatment** after your emergency **treatment**, please call us, as we may be able to cover this.

You may be able to claim a cash payment for each night you spend in an NHS hospital.

» For more details, see the benefits table

3 How your membership works

3.1 > Looking at who should provide treatment

3.2 > Eligible treatment

3.3 > Our cover for treatment and surgery

3.4 > How your membership works with pre-existing conditions and symptoms of them

3.5 > How your membership works with conditions that last a long time or come back (chronic conditions)

3.6 > Paying the specialists and practitioners that treat you

3.7 > Paying the places where you're treated

3.8 > Plan 3b members: How the NHS six week option works

3.9 > General restrictions

How your membership works

For full details of how your membership works, please read the rest of your handbook too.

Any questions?

If you're unsure how something works, just call us on 0800 068 7111 and we'll be very glad to explain. It's often quicker and easier than working it out from the handbook alone.

Making a claim

If you would like to make a claim, please call us on 0800 068 7111 and we'll be able to check your cover for you and tell you what to do next.

3.1 > Looking at who should provide treatment

Your membership does not cover primary care services such as any service that could be provided by GPs, dentists and opticians. This includes drugs and **treatment**.

When **diagnostic tests** are routinely required as part of your referral to a **specialist** we may arrange these for you. We do this to help the **specialist** to quickly and effectively diagnose or identify what **treatment** may be required.

3.2 > Eligible treatment

Your membership covers 'eligible **treatment**'.

You will need to read all sections of this handbook to understand whether **treatment** is eligible **treatment**.

'Eligible **treatment**' is **treatment** of a disease, illness or injury where that **treatment**:

- falls within the benefits of this **plan** and is not excluded from cover by any term in this handbook; and
- is of an **acute condition** (for details see 3.5) ; and
- is **conventional treatment** (for details see 3.3); and
- is not preventative (for details see 4.13); and
- does not cost more than an equivalent **treatment** that is as likely to deliver a similar therapeutic or diagnostic outcome; and
- is not provided or used primarily for the convenience or financial or other advantage of you or your **specialist** or other health professional

Treatment needs to meet all of these requirements. There are some exceptions which will be described in the relevant sections of this handbook. For example there are times when we do cover **treatment** of **chronic conditions** or **unproven treatment.** You will find more details of when that is the case in sections 3.3 and 3.5.

If we are not sure whether your **treatment** meets these requirements we may need a second medical opinion. We may ask a different specialist to give us a second opinion and they may need to examine you to confirm that your treatment is eligible **treatment**. In these cases, we will pay for the specialist to do this.

3.3 > Our cover for treatment and surgery

We cover **treatment** and **surgery** that is **conventional treatment**.

What do you mean by conventional treatment?

We define **conventional treatment** as **treatment** that:

- is established as best medical practice, and is practised widely within the **UK**; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the treatment is provided; and has either

- been shown to be safe and effective for the treatment of your medical condition through substantive peer reviewed clinical evidence in published authoritative medical journals; or
- been approved by NICE (The National Institute for Health and Care Excellence) as a treatment which may be used in routine practice.

Are there any additional requirements for drug treatments?

If the **treatment** is a drug, the drug must be:

- licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency; and
- used according to that licence.

Are there any additional requirements for surgical treatments?

If the **treatment** is a **surgical procedure** it must also be listed and identified in our schedule of procedures and fees.

» You can find our schedule at axapppphealthcare.co.uk/fees or call us on 0800 068 7111 and we'll send you a copy

What happens if my specialist says I need treatment that is not conventional treatment?

We know our members may want to have access to developing treatments as they become available. So, we will consider covering the following **treatment** when it is carried out by a **specialist**:

- **surgery** not listed and identified in the schedule of procedures and fees; and
- other **treatments** and **diagnostic tests** which are not **conventional treatments**.

In this handbook we refer to this **treatment** as **unproven treatment.**

The cover for **unproven treatment** is more restrictive than for **conventional treatments**. **Unproven treatment** must:

- be authorised by us before it takes place; and
- take place in the **UK**; and
- be agreed by us as a suitable equivalent to **conventional treatment**.

If there is no suitable equivalent **conventional treatment**, there won't be any cover for the **unproven treatment**.

Are there restrictions on what you pay for unproven treatment?

The amount we pay for **unproven treatment** will depend on how much it costs and how much we would pay if you have **conventional treatment** for your **medical condition** instead.

- If the **unproven treatment** costs less than the alternative **conventional treatment** we will pay the cost of the **unproven treatment**; or

- If the **unproven treatment** costs more than the equivalent **conventional treatment** we will pay up to the cost we would have paid for the equivalent **conventional treatment.** We will pay up to the amount we would have paid a recognised **specialist** and hospital in the **Specified Hospital List**. To understand what the equivalent **conventional treatment** is we will look at the **treatment** other patients with the same **medical condition** and prognosis would be given.

Do I need to let you know if I want unproven treatment?

Yes, if you would like an **unproven treatment** you or your **specialist** must contact us at least 10 working days before you book that **treatment**. This is so we can:

- obtain full details of the **treatment**; and
- support you with additional information and questions for your **specialist**, before you have **treatment** ; and
- agree what costs (if any) we will meet towards the hospital, **specialist**, anaesthetist and/or other provider. All **unproven treatment** must be agreed by us in writing, so you are clear how much we will pay towards your **treatment**.

We recommend you check with the hospital, **specialist**, anaesthetist and/or other provider how much they will charge for your **treatment** so you know how much will be your responsibility to pay.

Will there be any restrictions on my cover after I have had unproven treatment?

Yes there will. We will not pay for further **treatment** for your **medical condition** after you have undergone **unproven treatment**. This includes any complications or other **medical conditions** associated with the **unproven treatment.**

» To check whether we will agree to cover a treatment, please call us on 0800 068 7111 before you book your treatment.

3.4 > How your membership works with pre-existing conditions and symptoms of them

Health insurance is usually designed to cover **treatment** of new **medical conditions** that begin after you join. Your cover for **treatment** of conditions you were aware of or had already had when you joined depends on the type of cover your **group** has chosen and what you told us about your medical history when you joined.

What cover is there for treatment of any conditions I was aware of when I joined?

We call conditions you were aware of when you joined **pre-existing conditions**.

The definition of a **pre-existing condition**

A **pre-existing condition** is 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.

On your Certificate of Cover, you'll see one of the following codes.

This will tell you which underwriting terms you joined on. Here are the options:

- MORI = Moratorium
- FMU = Fully underwritten (or full medical underwriting)
- CPME = Continued personal medical exclusions
- MHD = Medical history disregarded
- VAR = various. This means that you and your dependants have different underwriting terms applied to them.

In the following panels, we've explained how each of these work, but if you're unsure about your cover for **treatment** of **pre-existing conditions** it's always best to call us.

Fully underwritten or full medical underwriting

'Fully underwritten' means we asked you for details of your medical history, including any **pre-existing conditions**, before you joined. We then worked out your cover based on the information we received.

We have listed any special terms or exclusions on your Certificate of Cover– please check this carefully. For example, you may not have cover for something specific if you have had that condition in the past.

Continue personal medical exclusions

If you joined us on 'continuing medical exclusions' terms, we are carrying on your exclusions for **medical conditions** from your previous health insurer. This normally means we only asked you a few brief medical questions.

We have listed any special terms or exclusions on your Certificate of Cover– please check this carefully. For example, you may not have cover for something specific if you have had that condition in the past. If we carried on a moratorium from your previous healthcare insurance, the rules of your moratorium may be slightly different, and we may start the moratorium from when it originally began on your previous insurance. Your Certificate of Cover will show when your moratorium started.

Medical history disregarded

If you joined us on 'medical history disregarded' terms, we accepted any **pre-existing conditions** you might have had when you joined. We normally only do this if we are continuing cover from a different health insurer or from a company membership, or for a newborn baby who was added to your membership.

Moratorium

If you joined us on moratorium terms, it means that you won't have cover for **treatment** of medical problems you had in the five years before you joined us until:

- you've been a member for two **years** in a row; and
- you've had a period of 24 consecutive months since you joined that have been trouble-free from that condition.

If you joined us from another health insurer, and we carried on your moratorium from that insurer, the rules may be slightly different, and we may start the moratorium from when it originally began on your previous insurance.

The definition of trouble free

If you joined on moratorium terms, what do we mean by trouble-free?

Trouble-free means that you have not done any of the following for the **medical condition** you need **treatment** for:

- had a medical opinion from a medical **practitioner**, including a **GP** or **specialist**
- taken medication (including over the counter drugs)
- followed a special diet
- had medical **treatment**
- visited a **practitioner**, **therapist**, homeopath, acupuncturist, optician or dentist.

If you joined on moratorium terms: some specific rules about diabetes, raised blood pressure and PSA tests

We will exclude **specified conditions** from your cover for at least two years after you join if:

- you you had pre-existing diabetes when you joined, or
- you have had **treatment** for raised blood pressure (hypertension) in the five years before you joined, or
- you have been investigated, monitored or treated as a result of a PSA (Prostate Specific Antigen) test to do with the prostate in the five years before you joined.

The **specified conditions** we will not cover are listed in the table below. We will not cover **treatment** for these **specified conditions** whatever the cause, even if they were not related to the **pre-existing condition**, and even if they develop after you joined.

Pre-existing conditions when you joined:	**Specified conditions** we do not cover
Diabetes	We will not cover **treatment** for: ▪ diabetes ▪ reduced blood supply to the heart muscle (ischaemic heart disease)

	▪ cataracts ▪ damage to the retina of the eye caused by diabetes (diabetic retinopathy) ▪ kidney disease caused by diabetes (diabetic renal disease) ▪ disease of the arteries ▪ stroke
If you have had **treatment** for raised blood pressure (hypertension) in the five years before you joined	We will not cover **treatment** for: ▪ raised blood pressure ▪ reduced blood supply to the heart muscle (ischaemic heart disease) ▪ stroke ▪ kidney failure as a result of high blood pressure (hypertensive renal failure)
If you have been investigated, monitored or treated as a result of a Prostate Specific Antigen (PSA) test in the five years before you joined	We will not cover **treatment** for: ▪ Any disorder of the prostate

You may be able to claim for these **specified conditions** after:

- you have been a member for two **years** in a row; and
- you have had two years in a row since you joined that have been **trouble free** from the **pre-existing condition**.

What if you didn't tell us about a condition, symptom or treatment you knew about when we asked?

Whichever form of underwriting you joined on, we may have asked you some medical questions before agreeing your cover. We worked out your terms or your subscription based on your answers. If you did not answer fully or accurately, even if this was by accident, we may not cover **treatment** for the condition.

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

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

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

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

3.5> How your membership works with conditions that last a long time or come back (chronic conditions)

Like most health insurance, your membership is designed to cover 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 longer time or come back (**chronic conditions**). However, there are particular situations where we can cover **treatment** for these kinds of conditions.

Does my membership cover me for treatment of conditions that last a long time or come back (chronic conditions)?

Your membership does not cover you for conditions that:

- come back; or
- are likely to continue for a while; or
- are long-term.

However, your membership will cover short-term **in-patient treatment** of flare-ups of a **chronic condition** – that is, unexpected complications or worsening of a **chronic condition**.

Because we don't cover ongoing, recurring long-term **treatment** for **chronic conditions**, this means we will not cover:

- monitoring a **medical condition**; or
- any **treatment** that only offers temporary relief of your symptoms, rather than dealing with the underlying condition; or
- routine follow-up consultations.

However, please see the notes on **treatment** for **cancer** and heart conditions below, as there are some exceptions to these rules.

What are acute conditions and chronic conditions?

Like most health insurers, we use the Association of British Insurers' definition for these.

Acute condition

An **acute condition** is 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 **chronic condition** is 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 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 happens if a condition I have is a chronic condition?

If your condition is chronic, unfortunately there will be a limit to how long we cover your **treatment**. If we are not able to continue to cover your **treatment**, we will tell you beforehand so that you can decide whether to start paying for the **treatment** yourself, or to transfer to the NHS.

How does this affect my cover for cancer treatment?

There is a full explanation of how we cover **cancer treatment** in section 4 of this handbook

How does this affect my cover for treatment of heart conditions?

We also make an exception for treating some heart conditions.

If you have any of the following **surgery** on your heart, we will carry on paying for long-term monitoring, consultations, check-ups, scans and examinations related to the **surgery**. We will continue to pay for this while you are still a member and have a **plan** with **out-patient** cover.

- coronary artery bypass
- cardiac valve **surgery**
- implanting a pacemaker or defibrillator
- coronary angioplasty.

We will not pay for routine checks that a **GP** would normally carry out, such as anticoagulation, lipid monitoring or blood pressure monitoring.

If you are diagnosed with a heart condition, you can speak to one of our **specialist nurses** for heart patients. They will be able to give you guidance and information about your condition and the **treatment** you are having.

What other treatment is covered for chronic conditions?

We will cover the following up to your **out-patient** limits:

- the initial investigations to diagnose your condition
- **treatment** for a few months, so that your **specialist** can start your **treatment**.

If your condition flares up or you develop complications, we will cover **in-patient treatment** to take your condition back to its controlled state.

Are there any conditions that are always regarded as chronic?

Yes. Some conditions are likely to always need ongoing **treatment** or are likely to recur. This is particularly the case if the condition is likely to get worse over time. An example is Crohn's disease (inflammatory bowel disease) and long-term depression.

If you have one of these conditions, we will contact you to tell you when we will stop cover for **treatment** of the condition. We will contact you so that you can then decide whether to start paying for the **treatment** yourself, or to transfer to the NHS.

3.6 > Paying the specialists and practitioners that treat you

Does my plan cover the full fees charged by specialists?

If your **treatment** is covered, using a recognised **specialist** gives you the maximum reassurance, as we pay all their fees. If you use our Fast Track Appointments service, and you would like us to book your appointment for you we will book it with a recognised **specialist**.

There are some specialists who we do not recognise. If you choose to see a specialist that we don't recognise, we do not pay any of their costs.

We use these arrangements for anaesthetists too – please also see below if you think your **treatment** will involve an anaesthetist.

Please also see the rest of this section for more about the people we pay.

Recognised specialists – what we pay

We will recommend you see a recognised **specialist**, as this will give you the maximum reassurance that the costs will be covered.

Call us as soon as you have seen your **GP**, and our Fast Track Appointments team can make your appointment with a recognised **specialist** for you.

This will mean that so long as your **treatment** is covered, we will pay for the following for a recognised **specialist**:

- Consultations (including remote consultations by telephone or via a video link. These will be covered under the **out-patient** consultation benefit if we have agreed with the **specialist** that he/ she is recognised by us to carry out remote consultations for our members).

- **diagnostic tests**
- hospital **treatment** at a **specified hospital**
- **surgery**.

This is so long as a **GP**, a dentist or a medical professional that we recognise and we have approved to make referrals has referred you for **treatment** with that type of **specialist**.

Specialists we do not pay for

We will not pay any of their costs, so you will need to pay all their costs yourself.

There are some specialists that we do not recognise. This means that we will not pay any of their fees, or any fees for **treatment** under their direction. If you do not want to pay for **treatment**, call us before you start **treatment**. We will be happy to find a **specialist** whose fees we will cover.

What about anaesthetists?

If you think that your **treatment** will involve an anaesthetist, please check with your **specialist** which anaesthetist they will use and let us know before your **treatment** starts. We will then be able to tell you whether we pay their fees (see 'Recognised **specialists**' above).

If you don't know which anaesthetist your **specialist** will use, we will do everything we can to let you know if they often use an anaesthetist that we do not pay in full.

As with other **specialists**, if the anaesthetist is a **specialist** that we do not pay, you will have to pay all of the fees yourself. Please see the panels above for the different arrangements we have with **specialists**.

Fast Track Appointments

Our Fast Track Appointments team can find up to three suitable specialists for you to choose from, and can even book your appointment for you. Just call us on 0800 068 7111.

Who will be paid for treatment as an out-patient?

We will pay for **out-patient** consultations with a **specialist** and the **diagnostic tests** that they say you need. We will pay so long as your **GP** refers you.

We will pay for **out-patient diagnostic tests** performed by your specialist up to the level shown in chapter 21 of our schedule of procedures and fees.

» For more about how we pay **specialists**, see the benefit table on page 4 and section 3.6

We will also pay for the **out-patient treatment** you need with a **practitioner**. By **practitioner** we mean a:

- nurse
- dietician
- orthoptist
- speech therapist
- audiologist

Plan 1, Plan 2, Plan 3: the definition of practitioner also includes:

- psychologist
- psychotherapist

We will pay so long as:

- a recognised **specialist** is directing your **treatment**
- your **specialist** refers you.

We pay **practitioner** fees up to the level shown in our schedule of procedures and fees.

» You can find our schedule at axappphealthcare.co.uk/fees or call us on 0800 068 7111 and we'll send you a copy

» Please note we have criteria for which practitioners we recognise and pay. Please see the Glossary for more information, or call us to check

Which therapies do you cover?

We will pay **out-patient treatment** fees up to the levels shown in the benefits table for any of the following that we recognise so long as your **treatment** is covered and your **GP** or **specialist** refers you:

- **physiotherapists**
- **acupuncturists**
- **homeopaths**
- osteopaths
- chiropractors.

If your **GP**, or for **treatment** from **physiotherapists**, osteopaths and chiropractors (**therapists**) our Working Body team, refers you for the **treatment**, you are covered for:

- Plan 1: an overall maximum of 20 sessions in a **year** with a **physiotherapist** and 20 sessions in a **year** for **treatment** with a **therapist**, **acupuncturist** or **homeopath**.
- Plan 2, Plan 3, Plan 4: an overall maximum of ten sessions in a **year** with a **physiotherapist** and ten sessions in a **year** for **treatment** with a **therapist**, **acupuncturist** or **homeopath**.

If your **specialist** or our Working Body team refers you, we may agree to more sessions, but will need to agree them first.

We pay **acupuncturists** and **homeopaths** up to the level shown in our schedule of procedures and fees.

We pay **physiotherapists**, osteopaths and chiropractors (**therapists**), in full if we recognise them. This is so long as they do not charge a significant amount more than they usually do, unless we have agreed this beforehand.

Please call us before you start **treatment** so we can confirm whether we recognise your **therapist**.

If you choose to use a **therapist**, **acupuncturist** or **homeopath** that we do not recognise, we will not pay for your **treatment**.

3.7 > Paying the places where you're treated

Where can I have treatment?

If your **treatment** is covered by your membership, we will pay your hospital fees in full. This is so long as a **specialist** is overseeing your **treatment**, and you use one of the following listed in our **Specified Hospital List**:

- a hospital
- a **day-patient unit**
- a **scanning centre** (for CT, MRI and PET scans).

In-patient and **day-patient** hospital fees include costs for things like:

- accommodation
- **diagnostic tests**
- using the operating theatre
- nursing care
- drugs
- dressings
- radiotherapy and chemotherapy
- physiotherapy
- surgical appliances that the **specialist** uses during **surgery**.

» For more about how we pay for treatment, please also see sections 3.6

There are special rules about the following kinds of **treatment**:

- **out-patient treatment**
- intensive care
- cataract **surgery**
- oral **surgery**.

» See next page for more details about these

What you must tell the place where you have your treatment

You must tell the place where you have your **treatment** that you are an AXA PPP healthcare member. This will help to ensure that the fees charged for your **treatment** are those we have agreed with the hospital or centre.

Where can I have out-patient treatment?

We will pay fees at an authorised **out-patient** facility in full. We will pay these so long as:

- your **treatment** is covered by your membership; and
- a **specialist** is overseeing it; and
- the facility is recognised by us to provide **out-patient** services.

Please always check with us beforehand to make sure the facility you want to go to is recognised.

CT, MRI or PET scans received as an **out-patient** will be paid in full at a **scanning centre** listed in our **Specified Hospital List**.

We do not pay for **out-patient** drugs or dressings.

What about intensive care?

If you have private intensive care **treatment** in a **specified hospital** or in an NHS Intensive Therapy or Intensive Care unit, we will pay for this so long as:

- it immediately follows private treatment that was covered by your membership; and
- you or your next of kin have asked for you to have the intensive care **treatment** privately.

Where can I have cataract surgery?

If you need cataract **surgery**, we will pay for your **treatment** at any **facility** where we have an agreement covering cataract **surgery**. These are shown in our **Specified Hospital List**. If your **GP** or optician says you need cataract surgery you need to contact us to find an appropriate **facility** for your **treatment.** The **facility** will put you in contact with one of their **specialists.**

Please contact us to find an appropriate **specialist** and **facility** for your **treatment**.

Does my plan cover payment for treatment anywhere else?

We only pay for **treatment** at the places listed. For example, we do not pay anything for **treatment** at a health hydro, spa, nature cure clinic or any similar place, even if it is registered as a hospital.

What happens if I choose a different hospital or scanning centre for treatment?

If you have private **in-patient** or **day-patient treatment** at a hospital, **day-patient unit** or use a **scanning centre** that is not in our **Specified Hospital List** we will not pay for your **treatment**. We will only pay a small cash payment as shown in the benefits table when **in-patient** or **day-patient treatment** received would have been covered by our membership. You will need to pay the majority of the cost yourself. This could be a significant amount.

What about treatment on the NHS?

If you have free **in-patient treatment** on the NHS that would have been covered by your membership, we will pay you a cash payment. This includes **treatment** in an NHS Intensive Therapy or Intensive Care unit or **treatment** received in a private facility.

» For more details, see the benefits table

3.8 > Plan 3b members: How the NHS six week option works

If you have Plan 3b your membership includes the NHS six week option.

This means that your cover is for **in-patient treatment**, **day-patient treatment** and any **surgical procedure** if the NHS can't give you that **treatment** within six weeks of when **treatment** should take place.

You can go privately for **out-patient** consultations, **diagnostic tests** that do not involve **surgery**, and CT, MRI or PET scans, whatever the length of the NHS wait.

Are there treatments that are not affected by the NHS six week option?

Yes. We will cover the following **treatment** regardless of the NHS waiting time.

This is because, except for radiotherapy and chemotherapy, they are usually not available within six weeks on the NHS.

- **day-patient** or **out-patient** radiotherapy or chemotherapy
- varicose veins **surgery**
- removing your tonsils with **surgery** (tonsillectomy)
- removing your adenoids with **surgery** (adenoidectomy)
- inserting grommets into the ear (to treat conditions like glue ear)
- removing bunions (hallux valgus)
- removing your gall bladder through keyhole **surgery** (laparoscopic cholecystectomy)
- removing piles (haemorrhoids) with **surgery** (haemorrhoidectomy)
- correcting a squint
- cataract **surgery**.

Does my NHS six week option mean there are types of treatment that are never covered?

Yes. You are not able to claim for any of the following:

- Urgent or emergency **treatment** because the NHS will cover this quickly.
- **Treatment** while you are pregnant or giving birth as the NHS will treat these quickly.

Do I have to wait until I get an NHS specialist appointment to claim?

No. You do not need to wait to see whether you can get an NHS **specialist** appointment within six weeks. Call us as soon as you have seen your **GP** and we will talk you through what happens next.

If you ask your **GP** for an 'open referral' and your **treatment** is covered, you can still benefit from our Fast Track Appointment service, where we can find you a convenient appointment quickly.

3.9 > General restrictions

High charges

We will not pay if any of the following charge a significant amount more than they usually do, unless we have agreed this beforehand:

- A recognised **specialist**
- a **physiotherapist**
- an osteopath
- a chiropractor
- a **practitioner**.

Consultations within 10 days of treatment

We will not pay any separate fee that your **specialist** makes for consultations within 10 days of carrying out **surgery**.

Treatment and referrals by family members

We will not pay for drugs or **treatment** if:

- the person who refers you is a member of your family
- the person who treats you is a member of your family.

4 Your cover for specific conditions, treatment, tests and costs

4.1 > Cancer
4.2 > Alcohol abuse, drug abuse, substance abuse
4.3 > Breast reduction
4.4 > Chiropody and foot care
4.5 > Consequences of previous treatment, medical or surgical intervention or body modification
4.6 > Contraception
4.7 > Cosmetic surgery
4.8 > Criminal activity
4.9 > Drugs and dressings
4.10 > External prostheses or appliances
4.11 > Fat removal
4.12 > Gender re-assignment or gender confirmation
4.13 > Genetic tests, preventative treatment and screening tests
4.14 > GP and primary care services
4.15 > Infertility and assisted reproduction
4.16 > Kidney dialysis
4.17 > Learning and developmental disorders
4.18 > Long sightedness, short sightedness and astigmatism
4.19 > Mechanical heart pumps (Ventricular Assist Devices (VAD) and Artificial Hearts)
4.20 > Mental health
4.21 > Natural ageing
4.22 > Nuclear, biological or chemical contamination and war risks
4.23 > Organ or tissue donation
4.24 > Pregnancy and childbirth

4.25 > Reconstructive surgery
4.26 > Rehabilitation
4.27 > Self-inflicted injury and suicide
4.28 > Sexual dysfunction
4.29 > Social, domestic and other costs unrelated to treatment
4.30 > Sports related treatment
4.31 > Sterilisation
4.32 > Teeth and dental conditions
4.33 > Treatment abroad and restrictions if you live outside of the UK
4.34 > Treatment that is not medically necessary
4.35 > Varicose veins
4.36 > Warts
4.37 > Weight loss treatment

There are particular rules for how we cover some conditions, treatments, tests and costs. This section explains what these are.

You should read this section alongside the other sections of this handbook as the other rules of cover will also apply, for example our rules about **pre-existing conditions**, **chronic conditions** and who we pay.

If you're at all unsure about the cover you have with your membership – even if you don't need to claim for it at the moment – please just give us a call on 0800 068 7111. We'll always be glad to explain your cover, and it's often quicker and easier than working it out from the handbook alone.

Any questions?

Just call us on 0800 068 7111 and we'll be very glad to help explain anything that's unclear.

If you want to make a claim, please call us on 0800 068 7111 first and we'll be able to check your cover for you and tell you what to do next.

4.1 > Cancer

Due to the nature of **cancer**, we cover it a little differently to other conditions. This section explains the differences. If a specific aspect of your cover is not mentioned here, the standard cover described elsewhere in your handbook applies.

Plan 4 members: please see section 4.1b for information on your cover for cancer.

4.1a > Comprehensive cancer cover for Plan 1, Plan 2 and Plan 3

About your cover for cancer treatment

We will cover investigations into **cancer** and **treatment** to kill **cancer** cells.

We will cover **treatment** for any new **cancer** that starts after you join. We will also cover that **cancer** if it comes back and you are still a member.

If you have exclusions to do with **cancer** because of your past medical history, we will not cover your **treatment** if this **cancer** comes back.

» For more details of how we cover treatment of pre-existing medical conditions, see section 3.4

Experienced dedicated nurses and case managers

Our registered nurses and case managers provide support over the phone and have years of experience of supporting cancer patients and their families. When you call, we will put you in touch with a nurse or case manager who will then support you throughout your treatment.

Your nurse or case manager will be happy to speak to your specialist or doctor directly if you need them to check any details. They can also give you guidance on what to expect during treatment and how to talk about your illness to friends and family.

Supporting you if you're diagnosed with cancer

Expert support if you choose to have your treatment on the NHS.

We have developed extra support services to help you and your family if you are diagnosed with **cancer** and you decide to have your **treatment** on the NHS instead of using this **plan** to have private **treatment**. We may be able to help you with everyday concerns, such as childcare or domestic help.

Please call us before your **treatment** begins, so that we can discuss with you what kind of expert support is available.

If you are diagnosed with **cancer** – please call us on 0800 068 7111 so we can explain how we can support you.

Cash payment for NHS treatment

If you have **day-patient** or **out-patient** radiotherapy or chemotherapy on the NHS, and your **plan** would have covered that **treatment**, we will make a cash payment as shown in the benefits table.

We will also make a cash payment for **in-patient treatment** on the NHS (as well as **out-patient** and **day-patient** radiotherapy or chemotherapy).

Nurse to give you chemotherapy by intravenous drip at home

We will pay in full for **treatment**:

- at home; or
- somewhere else that is appropriate.

We will pay for a **nurse** to give you chemotherapy to treat **cancer** by intravenous drip. This is so long as:

- we have agreed the **treatment** beforehand; and
- you would otherwise need to be admitted for **in-patient** or **day-patient treatment**; and
- the **nurse** is working under the supervision of a recognised **specialist** – see 3.6; and
- the **treatment** is provided through a healthcare services supplier that we have a contract with for this kind of service.

Do the rules about chronic or recurring conditions apply to cancer?

We don't apply our rules about chronic or recurring conditions to **cancer**. Please carefully read all of this section (4.1) to find out how we cover **treatment** for **cancer**.

How does cancer cover affect out-patient cover?

If you have been diagnosed with **cancer** your **plan** will cover **out-patient specialist** consultations and **out-patient diagnostic tests** without affecting your overall **out-patient** benefit.

Comparing our cancer cover

To help make our **cancer** cover clearer, the following information is in a format that the Association of British Insurers (ABI) recommend.

Place of treatment	Am I covered?
Private hospitals, **day-patient units** or **scanning centres** listed in our **Specified Hospital List**	✓ Yes
Private hospitals, **day-patient units** or **scanning centres** not listed in our **Specified Hospital List**	× No

Chemotherapy by intravenous drip at home.	✓ Yes
Treatment at a hospice.	✓ We will make a charitable donation of £75 for every night you spend in a hospice or have hospice at home care.
Diagnostic	**Am I covered?**
Whether you are an **in-patient**, **day-patient** or **out-patient**	
Diagnostic **surgery** as shown below under '**Surgery**'.	✓ Yes
CT, MRI and PET scans.	✓ Yes
Genetic testing proven to help choose the best chemotherapy. » See section 4.13 for more information on genetic tests.	✓ Yes
Genetic testing to work out whether you have a genetic risk of developing **cancer**.	× No
If you're an **in-patient** or **day-patient**	
Specialist fees for the **specialist** treating your **cancer** when you are an **in-patient** or **day-patient**.	✓ Yes
Diagnostic tests as an **in-patient** or **day-patient**.	✓ Yes
If you're an **out-patient**	
Specialist consultations with the **specialist** treating your **cancer** when you are an **out-patient**.	✓ Yes
Diagnostic tests as an **out-patient** when ordered or performed by the **specialist** treating your **cancer**.	✓ Yes

Surgery	Am I covered?
Whether you are an **in-patient**, **day-patient** or **out-patient**	
Surgery for the **treatment** or diagnosis of **cancer**, so long as it is **conventional treatment**. » See section 7 for how we define surgery. » See 3.3 for more about conventional and unproven treatment.	✓ Yes
Preventative	**Am I covered?**
Preventative **treatment**, such as: Screening when you do not have symptoms of **cancer**. For example, if you had a screen to see if you have a genetic risk of breast **cancer**, we would not cover the screening or any **treatment** to reduce the chances of developing breast **cancer** in future (such as a preventative mastectomy). Vaccines to prevent **cancer** developing or coming back – such as vaccinations to prevent cervical **cancer**.	× No
Drug therapy	**Am I covered?**
Out-patient drugs or other drugs that a **GP** could prescribe or could be bought over the counter. This includes drugs or prescriptions you are given to take home if you have had **in-patient**, **day-patient** or **out-patient treatment**.	Please call us about these drugs. We don't cover them, but we can help you apply to get these paid for by the NHS. Call us on 0800 068 7111 and we can talk you through this.
Drug **treatment** to kill **cancer** cells – including: ▪ biological therapies, such as Herceptin or Avastin ▪ chemotherapy.	✓ Yes There is no time limit on how long we cover these drugs. We will cover them if: ▪ they have been licensed by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency, and ▪ they are used according to their licence, and

	▪ they have been shown to be effective. Because drug licences change, this means that the drugs we cover will change from time to time. Please call once you know your treatment plan.
Unproven drugs.	× No. There is no cover for unproven drugs or drugs that are being used outside of their licence. » Please see section 3.3 for more information on unproven treatment.
Other drugs. We cover: ▪ Bone strengthening drugs such as bisphosphonates or Denosumab ▪ Hormone therapy that is given by injection (for example goserelin, also known as Zoladex) ▪ Antivirals, antibiotics, antifungals, anti-sickness and anticoagulant drugs.	✓ Yes. They are covered as long as you have them at the same time as you are having chemotherapy or biological therapy to kill **cancer** cells covered by your membership.
Drugs for treating conditions secondary to **cancer**, such as erythropoietin (EPO).	✓ Yes, while you are having chemotherapy that is covered by your membership.
Radiotherapy	**Am I covered?**
Radiotherapy including when it is used to relieve pain.	✓ Yes
Proton Beam Therapy (PBT)	✓ Yes We will pay for PBT for: - central nervous system (brain and spinal cord) **cancer** or malignant solid cancers in members aged 21 and under - chordomas or chondrosarcomas (types of spine **cancer**) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised) - **cancer** of the iris, ciliary body or choroid parts of the eye (uveal melanoma) which has not spread (metastasised)

	As PBT is a developing area of medicine there are only a limited number of facilities that provide this **treatment**. Please contact us before you have your **treatment**.
Accelerated charged particle therapies	× No. However, there is limited cover for proton beam therapy in the circumstances shown above.
Palliative and end of life care	**Am I covered?**
Care to relieve pain or other symptoms rather than cure the **cancer**.	✓ We will provide cover and support throughout your **cancer treatment** even if it becomes incurable. We cover radiotherapy, chemotherapy and **surgery** (such as draining fluid or inserting a stent) to relieve pain.
Donation to a hospice where you are having end of life care, or a donation to a service providing hospice at home care.	✓ £75 a night
Monitoring	**Am I covered?**
Follow ups – cover for follow up consultations and reviews for **cancer**.	✓ Yes, so long as you are still a member and have a **plan** that covers this.
Routine monitoring or checks that a **GP** or someone else in a **GP surgery** (or other primary care setting) could carry out.	× No
Follow up procedures that are for monitoring rather than **treatment**. Some **cancer** patients need procedures to check whether **cancer** is still present or has returned. For example, these could include colonoscopies to check the bowel or cystoscopies to check the bladder.	✓ Yes
Limits	**Am I covered?**
Time limits on **cancer treatment**. Your membership covers you while you are having **treatment** to kill **cancer** cells.	None

Money limits on **cancer treatment**	No specific limits – same rules apply to your **cancer treatment** as for any other **treatment**.
Other benefits	**Am I covered?**
Stem cell or bone marrow **treatment**. This includes paying reasonable costs to a live donor to donate bone marrow or stem cells. It does not include any related administration costs. For example, we will not cover transport costs or the costs of finding a donor. » See 4.23 for more about this.	✓ Yes
The cost of wigs or other temporary head coverings or **external prostheses** needed because of **cancer** whilst you are having **treatment** to kill **cancer** cells.	✓ Up to £400 a **year** for wigs or head coverings and up to £5,000 a **year** for prostheses.

4.1b > Cancer cover - NHS Cancer Support

If you have Plan 4 we will not pay for the **treatment** of **cancer**. You will need to use the NHS or pay for the costs of **treatment** yourself.

We will pay for a licensed **cancer** drug which the NHS will not pay for. We will also pay for the cost of the drug to be given to you.

We will pay if:

- a **specialist** recommends and prescribes the drug; and
- the drug is licensed by the European Medicines Agency (EMA) or the Medicines and Healthcare products Regulatory Agency; and
- the drug is being used according to its licence; and
- we have agreed the drug **treatment** in advance; and
- the intention of the drug is the affect the growth of the **cancer** by shrinking it, stabilising it or slowing the spread of disease and not just to relieve symptoms.

We will pay for the drugs to be given to you at home by a qualified and experienced healthcare professional. If it isn't appropriate for you to have the drugs at home they can be given to you at a hospital or **day-patient unit** listed in the **Specified Hospital List**.

4.2 > Alcohol abuse, drug abuse, substance abuse

We do not cover **treatment** you need as a result of, or in any way connected to, alcohol abuse, drug abuse or substance abuse.

4.3 > Breast reduction

We do not cover either male or female breast reduction.

4.4 > Chiropody and foot care

We will not cover any general chiropody or foot care, even if a surgical podiatrist provides it. This includes things like gait analysis and orthotics.

4.5 > Consequences of previous treatment, medical or surgical intervention or body modification

If you had **treatment**, medical or surgical intervention or body modification previously that would not be covered by your membership, we do not cover further **treatment** or increased **treatment** costs that are:

- a result of the **treatment**, medical or surgical intervention or body modification you had previously, or
- connected with the **treatment**, medical or surgical intervention or body modification you had previously.

4.6 > Contraception

We do not cover contraception or any consequence of using contraception.

4.7 > Cosmetic surgery

We do not cover:

- Cosmetic **treatment** or cosmetic **surgery**; or
- **treatment** that is connected to previous cosmetic **treatment** or cosmetic **surgery**.

» See also 4.25 Reconstructive surgery

4.8 > Criminal activity

We do not cover **treatment** you need as a result of your active involvement in criminal activity.

4.9 > Drugs and dressings

We do not cover drugs, dressings or prescriptions that:

- you are given to take home after you have had **in-patient**, **day-patient** or **out-patient treatment**; or
- could be prescribed by a **GP** or bought without a prescription; or
- are taken or administered when you attend a hospital, consulting room or clinic for **out-patient treatment**.

There are some exceptions for drugs given for **cancer treatment**.

» There is a full explanation of how we cover cancer treatment in section 4.1 of this handbook.

4.10 > External prostheses or appliances

What is covered?

We will pay up to £5,000 towards the cost of an **external prosthesis** needed following an accident or **surgery** for a **medical condition**.

We will do this so long as:

- you had continuous cover on a private medical insurance policy before the accident or **surgery** happened that has led to the need for the prosthesis; and
- all claims are made within 12 months of the amputation or removal of the body part

We will only pay this benefit once, regardless of how long you remain a member of PHC.

What is not covered?

We do not cover replacement of teeth or hair, including wigs or hair transplants.

We do not cover the costs of the purchase, hire or fitting of an external appliance, such as crutches, joint supports and braces, mechanical walking aids, contact lenses or any external device.

How to claim

If you want to claim this benefit, you should call us on 0800 068 7111 and we will explain what to do next. Please remember to ask the provider of your **external prosthesis** for full receipts as we cannot pay claims without a receipt.

4.11 > Fat removal

We do not cover the removal of fat or surplus tissue, such as abdominoplasty (tummy tuck), whether or not the removal is needed for medical or psychological reasons.

4.12 > Gender reassignment or gender confirmation

We do not cover gender re-assignment or gender confirmation **treatment** or anything connected with them in any way, such as:

- gender reassignment operations or other surgical **treatment**; or
- psychotherapy or similar services; or
- any other **treatment**.

4.13 > Genetic tests, preventative treatment and screening tests

Health insurance is designed to cover problems that you're experiencing at the moment, so it generally doesn't cover preventative **treatment** or screening tests, including genetic tests.

What is not covered for genetic tests, preventative treatment and screening tests?

We do not pay for:

- preventative **treatment**, such as preventative mastectomy; or
- preventative screening tests; or

- routine preventative examinations and check-ups; or
- genetic screening tests to check whether:
  - you have a **medical condition** when you have no symptoms; or
  - you have a genetic risk of a developing a **medical condition** in the future; or
  - there is a genetic risk of you passing on a **medical condition**.
- genetic tests to identify a **medical condition** where the result of the test isn't proven to change the course of **treatment**. This might be because the course of **treatment** for your symptoms will be the same regardless of what **medical condition** has caused them; or
- any other preventative screening or treatment to see if you have a **medical condition** whether or not you have symptoms; or
- vaccinations.

What is covered for genetic tests?

We will pay for genetic testing when it is proven to help choose the best course of drug **treatment** for your **medical condition**. This means that it must be recommended in the drug licence for a specific targeted therapy, such as HER2 testing for the use of Herceptin for breast **cancer**.

Please call us before you have any genetic tests to confirm that we will cover them. Your **specialist** might want to do a variety of tests and they might not all be covered. The cost to you might be significant if the tests aren't covered under your **plan**.

If you're unsure whether your **treatment** is preventative or not, please call us on 0800 068 7111 before going ahead with the **treatment**.

4.14 > GP and primary care services

We do not cover primary care services or **treatment** that would normally be carried out in a primary care setting. This includes any fees for services that a **GP**, dentist or optician could normally carry out, or any other primary care services.

4.15 > Infertility and assisted reproduction

We do not cover investigation or **treatment** of infertility and assisted reproduction or **treatment** designed to increase fertility. This includes:

- **treatment** to prevent future miscarriage; or
- investigations into miscarriage; or
- assisted reproduction; or
- anything that happens, or any **treatment** you need, as a result of these **treatments** or investigations.

4.16 > Kidney dialysis

We do cover kidney dialysis, but only in some situations.

What is covered for kidney dialysis?

We will cover kidney dialysis for up to six weeks if you are being prepared for kidney transplant. However, we will not cover regular or long-term kidney dialysis if you have chronic kidney failure.

» See also 4.23 > Organ or tissue donation

4.17 > Learning and developmental disorders

We do not cover any **treatment**, investigations, assessment or grading to do with:

- learning disorders
- speech delay
- educational problems
- behavioural problems
- physical development
- psychological development.

Some examples of the conditions we do not cover are the following (please call if you would like to know if a condition is covered):

- dyslexia
- dyspraxia
- autistic spectrum disorder
- attention deficit hyperactivity disorder (ADHD)
- speech and language problems, including speech therapy needed because of another **medical condition**.

4.18 > Long sightedness, short sightedness and astigmatism

We do not cover any **treatment** to correct refractive errors, including long sightedness, short sightedness or astigmatism.

4.19 > Mechanical heart pumps (Ventricular Assist Devices (VAD) and Artificial Hearts)

There is no cover for the provision or implantation of a mechanical heart pump. There is also no cover for the long-term monitoring, consultations, check-ups, scans and examinations related to the implantation or the device.

4.20 > Mental health

Our cover for mental health depends on which Plan you have.

There is no cover for mental health **treatment** if you have Plan 1a, Plan 2a, Plan 3a, Plan 3b or Plan 4.

What happens if I need to go into hospital for a psychiatric condition?

If you need to go into hospital for **in-patient** or **day-patient treatment** of a psychiatric condition, the hospital will contact us to check your cover before you go in. If your **treatment** is covered, we will agree to pay the hospital for an initial period of time in hospital. The hospital will tell you how long this period is.

If you need to stay in hospital for a longer period, we will ask your **specialist** why you need further **treatment**, and let you know if we agree to cover the extended stay.

What if my condition goes on for a long time?

Our normal rules on **chronic conditions** apply to mental health problems. So if your condition becomes chronic, unfortunately we may no longer be able to cover your **treatment**. If this happens, we will contact you beforehand so that you can decide whether to start paying for the **treatment** yourself, or to transfer to the NHS.

» For more details, see 3.5

What is not covered?

Even if you have cover for mental health **treatment**, we do not cover any **treatment** connected in any way to:

- an injury you inflicted on yourself deliberately; or
- a suicide attempt

4.21 > Natural ageing

We do not pay for **treatment** of symptoms generally associated with the natural process of ageing. This includes **treatment** for the symptoms of puberty and menopause, including symptoms as a result of medical intervention.

4.22 > Nuclear, biological or chemical contamination and war risks

We do not cover **treatment** you need as a result of nuclear, biological or chemical contamination. We do not cover **treatment** you need as a result of war (declared or not), an act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons, or any similar event.

We do cover **treatment** due to a **terrorist act** so long as the act does not cause nuclear, biological or chemical contamination.

4.23 > Organ or tissue donation

Plan 1, Plan 2, Plan 3 for the **treatment** of **cancer**: If you plan to donate an organ or tissue as a live donor, or receive an organ or tissue from a live donor, please call us so that we can tell you what support we offer.

What we don't cover

We do not pay for:

- the cost of collecting donor organs or tissue; or

- any related administration costs – for example, the cost of searching for a donor; or
- any costs towards organ or tissue donation that is not done in line with appropriate regulatory guidelines
- any costs towards organ or tissue donation that is not for the **treatment** of **cancer**.

4.24 > Pregnancy and childbirth

As pregnancy and childbirth are not **medical conditions** and because the NHS provides for them, our cover is limited.

We don't cover the checks or other interventions, such as antenatal and postnatal monitoring and screening that you will have during pregnancy and birth.

What is covered?

We will cover the additional costs for **treatment** of **medical conditions** that arise during your current pregnancy or childbirth. For example:

- ectopic pregnancy (pregnancy where the embryo or foetus grows outside the womb)
- hydatiform mole (abnormal cell growth in the womb)
- retained placenta (afterbirth retained in the womb)
- eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
- post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
- miscarriage requiring immediate surgical **treatment**.

Because our cover for pregnancy and childbirth is limited, please call us on 0800 068 7111 to check what you are covered for before starting any private **treatment**.

If you have a baby, we can often add them to your membership from birth. However, if the baby was born after fertility **treatment** or assisted reproduction, there are a few limits on our cover. Please call us on 0800 068 7111 so we can explain what we can cover.

4.25 > Reconstructive surgery

We do cover reconstructive **surgery**, but only in certain situations.

What is covered?

We will cover your first reconstructive **surgery** following an accident or **surgery** for a **medical condition** that was covered by your membership. We will do this so long as:

- you had continuous cover under a private medical health insurance plan before the accident or **surgery** happened; and
- we agree the method and cost of the **treatment** beforehand.

In the case of breast cancer the first reconstructive **surgery** means:

- one planned **surgery** to reconstruct the diseased breast
- one further planned **surgery** to the other breast, when it has not been operated on, to improve symmetry
- nipple tattooing, up to 2 sessions.

Please call us on 0800 068 7111 before agreeing to reconstructive surgery so we can tell you if you are covered.

What is not covered?

We do not cover **treatment** that is connected to previous reconstructive surgery or any cosmetic operation to a reconstructed breast.

» See also 4.6

4.26 > Rehabilitation

We do cover **in-patient** rehabilitation for a short period, but there are some limits to our cover.

What is covered for rehabilitation?

We will cover **in-patient** rehabilitation for up to 28 days, so long as:

- it follows an acute brain injury, such as a stroke; and
- it is part of **treatment** of an **acute condition** that is covered by your membership; and
- a **specialist** in rehabilitation is overseeing your **treatment**; and
- you have your **treatment** in a rehabilitation hospital or unit which we have written to confirming it's recognised by us; and
- the **treatment** can't be carried out as a **day-patient** or **out-patient**, or in another suitable location; and
- we have agreed the costs before you start rehabilitation.

If you have severe central nervous system damage following external trauma, we will extend this cover to up to 180 days of **in-patient** rehabilitation.

If you need rehabilitation, please call us on 0800 068 7111, as we will need to confirm that we recognise the hospital or unit where you are having the rehabilitation.

4.27 > Self-inflicted injury and suicide

We do not cover **treatment** you need as a direct or indirect result of a deliberately self-inflicted injury or a suicide attempt.

4.28 > Sexual dysfunction

We do not cover **treatment** for sexual dysfunction or anything related to sexual dysfunction.

4.29 > Social, domestic and other costs unrelated to treatment

We do not cover the costs that you pay for social or domestic reasons, such as home help costs. We do not cover the costs that you pay for any reasons that are not directly to do with **treatment** such as travel to or from the place you are being treated

4.30 > Sports related treatment

We do not cover **treatment** you need as a result of training for or taking part in any sport for which you:

- are paid; or
- receive grants or sponsorship (we do not count travel costs in this); or
- are competing for prize money.

4.31 > Sterilisation

We do not cover:

- sterilisation; or
- any consequence of being sterilised; or
- reversal of sterilisation; or
- any consequence of a reversal of sterilisation.

4.32 > Teeth and dental conditions

You do not have cover for treating dental problems or any routine dental care, treatment of cysts in the jaw that are tooth related or are of dental origin, this also means we will not pay any fees for dental **specialists**, such as orthodontists, periodontists, endodontists or prosthodontists.

We will cover the following types of oral **surgery** when you are referred for **treatment** by a dentist:

- reinserting your own teeth after an injury; or
- removing impacted teeth, buried teeth and complicated buried roots; or
- removal of cysts of the jaw (sometimes called enucleation).

4.33 > Treatment abroad and restrictions if you live outside of the UK

We do not cover any costs for **treatment** you receive outside the **UK**.

We do not cover any costs for **treatment** if you live outside the **UK**.

4.34 > Treatment that is not medically necessary

Like most health insurers, we only cover **treatment** that is medically necessary. We do not cover **treatment** that is not medically necessary, or that can be considered a personal choice.

4.35 > Varicose veins

We do cover **treatment** of varicose veins, but only in certain circumstances.

What is covered?

We will cover one **surgical procedure** per leg to treat varicose veins, for the lifetime of your membership with us. This may be foam injection (sclerotherapy), ablation or other **surgery**.

We will cover one follow up consultation with your **specialist** and one simple injection sclerotherapy per leg to treat residual or remaining veins when it is carried out in the 6 months after you've had the main **surgical procedure**.

What's not covered?

We do not cover more than one **surgical procedure** per leg, regardless of how long you stay a member with us.

There is no cover for the **treatment** of recurrent varicose veins under your **plan**.

» Please see 'How your membership works with conditions that last a long time or come back (chronic conditions)'

There is no cover for the **treatment** of thread veins or superficial veins.

4.36 > Warts

We do not cover **treatment** of skin warts.

4.37 > Weight loss treatment

We do not cover **treatment** for weight loss.

What is not covered?

We do not cover any fees for any kind of bariatric (weight loss) **surgery**, regardless of why the **surgery** is needed. This includes fitting a gastric band, creating a gastric sleeve, or other similar **treatment**.

5 Managing your membership

5.1 > Adding a family member or baby
5.2 > Paying your excess
5.3 > Keeping us informed
5.4 > If you move abroad
5.5 > Paying income tax on your subscription
5.6 > Cancelling your membership
5.7 > Leaving your group
5.8 > Making a complaint

5.1 > Adding a family member or baby

Whether you can add **family members**, including babies, to your cover will depend on the agreement we have with your **group**. Depending on your agreement with your **group**, there may be restrictions on when you can add **family members**.

Please ask your **group** administrator if you wish to add a **family member** or baby.

Who you can add

You can normally add:

- Your partner. You must be either married, in a civil partnership, or living together permanently in a similar relationship.
- Any of your children or your partner's children.

If you would like to add a new baby to your cover, you can normally do this from their date of birth, so long as you let us know within three months of their birth.

We normally will not need details of their medical history.

Babies born after fertility treatment, or following assisted reproduction, or who you have adopted

You can add a baby born after fertility **treatment**, or following assisted reproduction (such as IVF), or who you've adopted, to your membership. As with most health insurance, our cover for **treatment** has a few limits in these situations.

If a baby is born after fertility **treatment**, or following assisted reproduction, or if you have adopted a baby:

- We may ask for more details of the baby's medical history.
- We will not cover any **treatment** in a Special Care Baby Unit or paediatric intensive care.

- We may add other conditions to the baby's cover. For example, we may limit their cover for **pre-existing conditions**.

We count fertility treatment as taking any prescription or non-prescription drug or other **treatment** to increase fertility.

5.2 > Paying your excess

Your Certificate of Cover will tell you if you have an excess and how much it is. This section tells you how to pay it.

If you have an excess

If you have excess to your membership, you can see the amount on your Certificate of Cover. Here is how excesses work:

- We will take your excess off the amount covered by your **plan** for the first claim for each person in each membership **year**. For example, if the claim was covered for £800, and the excess was £100, we would pay £700.
- If your claim is for a **treatment** that has a limit we will apply the limit before we take the excess off.
- We count the **treatment** costs for each **year** according to the date the **treatment** took place.
- Even if **treatment** costs less than your excess, please tell us about it so we can make sure we take this into account if you claim again that **year**.
- Your excess applies per person. So if two people covered by your membership claim, we will take the excess off both their claims.
- We only take off the excess once per person per membership **year**. So even if you claim several times, we will only take the excess off once. It does not matter whether you claim several times for the same **medical condition**, or for several **medical conditions**.
- It also applies for each membership **year**. This means that if you incur costs during this membership **year**, we will take the excess off what we pay for your claim. If you then incur more costs in the next membership **year**, even if it's for the same condition, we will take the excess off that claim.
- If your claim goes over your renewal, we will take the excess off the amount we pay for your claim before renewal, then we will take the excess off the amount we pay for your claim after renewal.

If you have any questions about how your excess works, please call us on 0800 068 7111.

» You can find an example of how we work out the excess below

Claims that you do not have to pay an excess for

If you claim for any of the following, you will not need to pay an excess:

- NHS radiotherapy and chemotherapy cash benefit.
- NHS cash benefit.

- Childbirth benefit
- Accidental death benefit
- Any claim for wigs, head coverings or hospice donations.

5.3 > Keeping us informed

If any of your personal details change, it's important that you let us know as soon as possible. If you're unsure whether the change is important, it's best to tell us and we can explain if it affects your membership.

Changes you must tell us about

If you send us any form, and anything changes between the time you send the form and the time we confirm that we have made the change shown in the form, you must tell us.

5.4 > If you move abroad

If you move abroad, you won't be able to keep your current membership and you will not be able to make any claims for **treatment**.

5.5 > Paying income tax on your subscription

If cover is available under an arrangement with your employer, you will have to pay income tax on the subscriptions paid by your employer, less any amount made good by you as the employee.

5.6 > Cancelling your membership

As your membership is part of a group membership that has been arranged by the **group** you are not able to cancel it. If you want to stop your membership to the plan, please contact your group administrator.

5.7 > Leaving your group

We'll try to get in touch with you when we know that you're leaving your **group**.

Call us on 0800 533 5962 when you know you're leaving.

If you leave the **group** that provides this **plan**, it's quick and easy to transfer to a personal **plan** with our underwriter AXA PPP healthcare.

When you transfer to a personal **plan** with similar cover, AXA PPP healthcare can usually continue to cover any existing **medical conditions** without the need for medical underwriting – so you won't have to fill in any forms or have a medical examination.

Call us as soon as you know you're leaving as you may find it difficult to get continued cover for any existing or previous **medical conditions** later.

We'll arrange everything over the phone.

5.8 > Making a complaint

Your cover is provided under our **group insurance contract** with your **group**. However we do give all members full access to the complaint resolution process.

Our aim is to make sure you're always happy with your membership. If things do go wrong, it's important to us that we put things right as quickly as possible.

Making a complaint

If you want to make a complaint, you can call us or write to us using the contact details below. To help us resolve your complaint, please give us the following details:

- your name and membership number
- a contact phone number
- the details of your complaint
- any relevant information that we may not have already seen.

Please call us on 01923 770 000.

Or write to: PHC Ltd, 32 Church Street, Rickmansworth, Hertfordshire, WD3 1DJ

Or email: support@thephc.co.uk

Answering your complaint

We'll respond to your complaint as quickly as we can.

If we can't get back to you straight away, we'll contact you within five working days to explain the next steps.

We always aim to resolve things within eight weeks from when you first told us about your concerns. If it looks like it will take us longer than this, we will let you know the reasons for the delay and regularly keep you up to date with our progress.

The Financial Ombudsman Service

If we cannot fully respond to your complaint within eight weeks, or you are unhappy with our final response, you can refer your complaint to the Financial Ombudsman Service for an independent review.

The Financial Ombudsman Service will be able to look into your complaint once eight weeks has passed since you first told us of your complaint, or once we've given you our final response if that's sooner.

The Financial Ombudsman Service
Exchange Tower
Harbour Exchange Square
London E14 9SR

Phone: 0300 123 9 123 or 0800 023 4567

Email: complaint.info@financial-ombudsman.org.uk

Website: financial-ombudsman.org.uk

Your legal rights

None of the information in section 5.8 affects your legal rights.

6 Legal information

6.1 > Rights and responsibilities

6.2 > Our authorisation and regulation details

6.3 > The Financial Services Compensation Scheme (FSCS)

6.4 > Your personal information

6.5 > What to do if somebody else is responsible for part of the cost of your claim

6.6 > What to do if your claim relates to an injury or medical condition that was caused by another person

6.1 > Rights and responsibilities

This section sets out the rights and responsibilities you, your **group** and we have to each other.

The plan

The cover is provided under a **group insurance contract**.

The **plan** is for one **year**.

Only those people listed in the **group insurance contract** can be members of this **plan**.

All cover ends when the **group's** group membership ends. Cover for **family members** ends when the **lead member's** cover ends.

The **group** is responsible for paying the **premium**.

We will pay for covered costs incurred during a period for which the **premium** has been paid.

If you pay a contribution to the **group** towards cover for the **lead member** or **family members** (for example by salary deduction or Direct Debit) it does not give you any rights under the **group insurance contract**, which is between the **group** and us.

We will confirm the date that the **plan** starts and ends, who is covered, and any special terms that apply.

Your Certificate of Coveris proof of your cover.

Renewal

At the end of each **plan year**, we will contact the **group** to tell them the terms the **plan** will continue on if the **plan** is still available. We will renew the **plan** on the new terms unless the **group** asks us to make changes or tells us they wish to cancel. You will be bound by those terms.

Providing us with information

Whenever we ask you to give us information, you will make sure that all the information you give us is sufficiently true, accurate and complete for us to be able to work out the risk we are considering. If we later discover that it is not, we can cancel the **plan** or apply different terms of cover in line with the terms we would have applied if the information had been presented to us fairly.

You must contact us if you change your address.

Our right to refuse to add a family member

We can refuse to add a **family member** to the **plan**. We will tell the **lead member** if we do this.

Subrogated rights

We, or any person or company that we nominate, have subrogated rights of recovery of the **lead member** or any **family members** in the event of a claim. This means that we will assume the rights of the **lead member** or any **family members** to recover any amount they are entitled to that we have already covered under this **plan**.

For example, we may recover amounts from someone who caused injury or illness, or from another insurer or a state healthcare provider.

The **lead member** must provide us with all documents, including medical records, and any reasonable assistance we may need to exercise these subrogated rights.

The **lead member** must not do anything to prejudice these subrogated rights.

We reserve the right to deduct from any claims payment otherwise due to you an amount that will be recovered from a third party or state healthcare provider.

What happens if you break the terms of your plan

If you break any terms of your **plan** that we reasonably consider to be fundamental, we may do one or more of the following:

- refuse to pay any claims;
- recover from you any loss caused by the break;
- refuse to renew your membership to the **plan**;
- impose different terms to the cover;
- end your membership to the **plan** and all cover immediately.

If you (or anyone acting on your behalf) claim knowing that the claim is false or fraudulent, we can refuse to pay that claim and may declare your membership to the **plan** void, as if it never existed. If we have already paid the claim we can recover what we have paid from you.

If we pay a claim and the claim is later found to be wholly or partly false or fraudulent, we will be able to recover what we have paid from you.

International Sanctions

We will not do business with any individual or organisation that appears on an economic sanctions list or is subject to similar restrictions from any other law or regulation. This includes sanction lists, laws and regulations of the European Union, **United Kingdom**, United States of America or under a United Nations resolution. We will immediately end cover and stop paying claims on your **plan** if you or a **family member** are directly or indirectly subject to economic sanctions, including sanctions against your country of residence. We will do this even if you have permission from a relevant authority to continue cover or subscription payments under a **plan**. In this case, we can cancel your **plan** or remove a **family member** immediately without notice, but will then tell you if we do this. If you know that you or a **family member** are on a sanctions list or subject to similar restrictions you must let us know within 7 days of finding this out.

What happens if the group insurance contract ends

If the **group insurance contract** ends, you can apply to transfer to another **plan**.

Legal rights

Each **family member** may make individual claims under the **plan**, which may be without the knowledge of the **lead member** in accordance with our approach to personal data. Only the **group** and we have legal rights under this **plan**. No clause or term of this **plan** will be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999, by any other person, including any **family member**. Consequently, the **lead member** remains liable for excesses and shortfalls incurred by a **family member** under the **plan**.

Law applying to your plan

The **group** and we are free to choose the law that applies to your **plan**. The law of England and Wales will apply unless you and we agree otherwise.

Language for your plan

We will use English for all information and communications about your **plan**.

6.2 > Our authorisation and regulation details

The Permanent Health Company Limited is authorised and regulated by the Financial Conduct Authority (FCA). AXA PPP healthcare is authorised by the Prudential Regulation Authority (PRA) and regulated by the Financial Conduct Authority (FCA) and the Prudential Regulation Authority.

The FCA sets out regulations for the sale and administration of general insurance. We must follow these regulations when we deal with you.

The PHC's FCA register number is 310293. AXA PPP healthcare's financial services register number is 202947.

You can check details of our registration on the FCA website: fca.org.uk

6.3 > The Financial Services Compensation Scheme (FSCS)

We are participants in the Financial Services Compensation Scheme (FSCS). The Scheme may act if it decides that an insurance **company** is in such serious financial difficulties that it may not be able to honour its contracts of insurance. It may do this by:

- providing financial assistance to the insurer
- transferring policies to another insurer
- paying compensation to **lead members**.

The Scheme was established under the Financial Services and Markets Act 2000 and is administered by the Financial Services Compensation Scheme Limited.

You can find more information about the scheme on the FSCS website: fscs.org.uk.

6.4 > Your personal information

Here is a summary of the data privacy notice that you can find on our website axappphealthcare.co.uk/privacynotice.

Please make sure that everyone covered by this **plan** reads this summary and the full data privacy notice on our website. If you would like a copy of the full notice call us on 0800 0687111 and we'll send you one.

We want to reassure you we never sell personal member information to third parties. We will only use your information in ways we are allowed to by law, which includes only collecting as much information as we need. We will get your consent to process information such as your medical information when it's necessary to do so.

We get information about you and the **family members** who are covered by your **plan** from you, those **family members**, your healthcare providers, your employer (if you are on a company scheme), your insurance broker if you have one and third party suppliers of information, such as credit reference agencies.

We process your information mainly for managing your membership and claims, including investigating fraud. We also have a legal obligation to do things such as report suspected crime to law enforcement agencies. We also do some processing because it helps us run our business, such as research, finding out more about you, statistical analysis for example to help us decide on premiums and marketing.

We may disclose your information to other people or organisations. For example we'll do this to:

- manage your claims, e.g. to deal with your doctors or any reinsurers;
- manage your plan with your insurance broker
- help us prevent and detect crime and medical malpractice by talking to other insurers and relevant agencies; and
- allow other AXA companies in the **UK** to contact you if you have agreed.

Where our using your information relies on your consent you can withdraw your consent, but if you do we may not be able to process your claims or manage your plan properly.

In some cases you have the right to ask us to stop processing your information or tell us that you don't want to receive certain information from us, such as marketing communications. You can also ask us for a copy of information we hold about you and ask us to correct information that is wrong.

If you want to ask to exercise any of your rights just call us on 01923 770 000 or write to us.

6.5 > What to do if somebody else is responsible for part of the cost of your claim

You must tell us if you are able to recover any part of your claim from any other party. Other parties would include:

- an insurer that you have another insurance policy with
- a state healthcare system
- a third party that has a legal responsibility or liability to pay. We will pay our proper share of the claim.

6.6 > What to do if your claim relates to an injury or medical condition that was caused by another person

You must tell us as quickly as possible if you believe someone else or something (i.e. a third party) contributed to or caused the need for your **treatment,** such as a road traffic accident, an injury or potential clinical negligence.

This does not change the benefits you can claim under your **plan** (your "Claim") and also means that you can potentially be repaid for any costs you paid yourself, such as your excess or if you paid for private treatment that wasn't covered by your **plan**. Where appropriate, we will pay our share of the Claim and recover what we pay from the third party.

Where you bring a claim against a third party (a "Third Party Claim"), you or your representatives) must:

- include all amounts paid by us for **treatment** relating to your Third Party Claim (our "Outlay") against the third party;
- include interest on our Outlay at 8% p.a;
- keep us fully informed on the progress of your Third Party Claim and any action against the third party or any pre-action matters;
- agree any proposed reduction to our Outlay and interest with us prior to settlement. If no such agreement has been sought we retain the right to recover 100% of our Outlay and interest directly from you;
- repay any recovery of our Outlay and interest from the third party directly to us within 21 days of settlement;
- provide us with details of any settlement in full.

In the event you recover our Outlay and interest and do not repay us this recovered amount in full we will be entitled to recover from you what you owe us and your plan may be cancelled in accordance with 'What happens if you break the terms of your **plan**'.

Even if you decide not to make a claim against a third party for the recovery of damages we retain the right (at our own expense) to make a claim in your name against the third party for our Outlay and interest. You must co-operate with all reasonable requests in this respect.

The rights and remedies in this clause are in addition to and not instead of rights or remedies provided by law.

If you have any questions please call 0800 068 7111 and ask for the Third Party Recovery team.

7 Glossary

Certain terms in this handbook have specific meanings. The terms and their meanings are listed in this glossary. Where we've highlighted these terms in bold they have a specific meaning.

◆ The terms marked with this symbol have meanings that are agreed by the Association of British Insurers. These meanings are used by most medical insurers.

acupuncturist – a medical practitioner who specialises in acupuncture who is registered under the relevant Act or a practitioner of acupuncture who is registered as a member of the British Acupuncture Council (BAcC): and who, in all cases, meets our criteria for acupuncturist recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise them as an acupuncturist for benefit purposes in that field for the provision of **out-patient treatment** only.

» The full criteria we use when recognising medical practitioners are available on request

acute 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.

cancer ◆ – a malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

care assistant – a person attached to a registered nursing agency as a carer or nurse auxiliary.

chronic condition ◆ – 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.

conventional treatment – **treatment** that:

- is established as best medical practice and is practised widely within the **UK**; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the **treatment** is provided; and has either
- been shown to be safe and effective for the **treatment** of your **medical condition** through substantive peer reviewed clinical evidence in published authoritative medical journals; or
- been approved by NICE (The National Institute for Health and Care Excellence) as a **treatment** which may be used in routine practice.

If the **treatment** is a drug, the drug must be:

- licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency; and
- used according to that licence.

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.

day-patient unit – a medical unit where **day-patient treatment** is carried out.

» The units we recognise are listed in our **Specified Hospital List** . Please call PHC for the latest list.

diagnostic tests ◆ - investigations, such as x-rays or blood tests, to find or to help to find the cause of your symptoms.

» The **diagnostic** tests we pay for when they are performed by your specialist are listed in chapter 21 of the schedule of procedures and fees

eligible members - the individuals currently employed by the **group** (and/or a company group) and accepted by AXA PPP healthcare as members under the plan or any other category of alternative members as set out in the Certificate of Insurance.

external prosthesis – an artificial, removable replacement for a part of the body

facility – a **specified hospital**, or unit listed in the **Specified Hospital List** with which we have an agreement to provide a specific set of medical services.

Some facilities may have arrangements with other establishments to provide **treatment**.

family member – 1) The **lead member**'s current spouse or civil partner or any person living permanently in a similar relationship with the **lead member**; and 2) any of their or the **lead member**'s children. Children cannot stay on your **plan** after the renewal date following their 25th birthday.

GP – a general practitioner on the General Medical Council (GMC) GP register.

>> We will only accept referrals from your NHS GP practice.

group - the company or legal entity who hold the **group** insurance policy with AXA PPP healthcare that the **plan** is part of.

group insurance contract - the contract we have with the **group** for the group private medical insurance policy.

homeopath – a medical **practitioner** with full registration under the Medical Acts, who specialises in homeopathy who is registered under the relevant Act or a **practitioner** of homeopathy who holds full membership of the Faculty of Homeopathy is registered with the Faculty of Homeopathy; and who, in all cases, meets our criteria for **homeopath** recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise them as a **homeopath** for benefit purposes in that field for **out-patient treatment** only.

» The full criteria we use when recognising medical practitioners are available on request

in-patient ◆ – a patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.

lead member – the first person named on your Certificate of Cover.

medical condition – any disease, illness or injury, including psychiatric illness.

nurse ◆ – a qualified nurse who is on the register of the Nursing and midwifery Council (NMC) and holds a valid NMC personal identification number

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**.

physiotherapist – a medical practitioner who practices physiotherapy and who meets our recognition criteria for benefit purposes in their field of practice and who we have told in writing that we currently recognise them as a physiotherapist for benefit purposes. When such persons provide such services to you as part of your **in-patient** or **day-patient treatment**, those services will form part of the private hospital charges.

plan – the insurance contract between the **group** and us. The full terms of your plan are set out in the latest versions of:

- the **group insurance contract**
- any application form we ask you to fill in
- any certificate of fact we send you
- this handbook
- your Certificate of Cover and our letter of acceptance.

practitioner – a dietician, **nurse**, orthoptist, speech **therapist** or audiologist that we have recognised. Plan 1, Plan 2 and Plan 3 the definition of practitioner also includes a psychologist or psychotherapist that we have recognised. We will pay for **treatment** by a **practitioner** if both the following apply:

- a **specialist** refers you to them
- the **treatment** is as an **out-patient**.

If the **treatment** is as an **in-patient** or **day-patient**, that **treatment** will be included as part of your private hospital charges.

» The full criteria we use when recognising practitioners are available on request

premium - the insurance premium amount payable by the **group** to AXA PPP healthcare for the **year** in return for AXA PPP healthcare providing this **group** insurance cover for the benefit of **eligible members** and **family members**.

scanning centre – a centre where **out-patient** CT (computerised tomography), MRI (magnetic resonance imaging) and PET (positron emission tomography) is carried out.

» The centres we recognise are listed in our **Specified Hospital List**

specialist – a medical **practitioner** who meets all of the following conditions:

- has specialist training in an area of medicine, such as training as a consultant surgeon, consultant anaesthetist, consultant physician or consultant psychiatrist
- is fully registered under the Medical Acts
- is recognised by us as a specialist.

The definition of a specialist who we recognise for **out-patient treatment** only is widened to include those who meet all of the following conditions:

- specialise in musculoskeletal medicine, sports medicine or podiatric **surgery**.
- is fully registered under the Medical Acts
- is recognised by us as a specialist.

» The full criteria we use when recognising specialists are available on request

specified chronic condition –angina, asthma, diabetes, epilepsy, heart valve problems, high blood pressure, glaucoma, osteoarthritis, rheumatoid arthritis, thyroid problems and ulcerative colitis.

Specified Hospital List – the list of hospitals, **day-patient unit**s and **scanning centres** that are available for you to use under the terms of your **plan**.

The list changes from time to time, so you should always check with us before arranging **treatment**. Some **treatment**s are only available in certain facilities.

» The facilities we recognise are listed in your **Specified Hospital List.** Please call PHC for the latest list.

specified hospital – a hospital listed in the current Specified Hospital List

surgery/surgical procedure – an operation or other invasive surgical intervention listed in the schedule of procedures and fees.

terrorist act – any act of violence by an individual terrorist or a terrorist group to coerce or intimidate the civilian population to achieve a political, military, social or religious goal.

therapist – a medical **practitioner** who meets all of the following conditions:

- is a **practitioner** in osteopathy or chiropractic **treatment**
- is fully registered under the relevant Acts
- is recognised by us as a therapist for **out-patient treatment**.

» The full criteria we use when recognising medical practitioners are available on request

treatment ◆ – surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

United Kingdom (UK) – Great Britain and Northern Ireland, including the Channel Islands and the Isle of Man.

year – the 12 months from your **plan** start date or last renewal date. If your membership to the **plan** began part way through the **plan** year, your first year of cover will run until the next renewal date.

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Write to us at: AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL.

We may record and/or monitor calls for quality assurance, training and as a record of our conversation.

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