health-on-line

Business Priority Health Handbook
Details of your Business Priority Health insurance plan

April 2018

Welcome

Thank you for choosing Business Priority Health from Health-on-Line.

There is a lot of detail in this handbook, but we want to make sure you've got all the information you need.

We've tried to make everything easy to follow so that your cover is easy to understand, but there's a lot to explain and healthcare can be complicated.

If anything is not clear, please call us.

Questions about the plan

0800 587 0957

Monday to Friday 8am to 6pm

Claims

0345 600 7696

Monday to Friday 8am to 6pm

24 hour medical help and information

0800 003 004

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

We are committed to giving customers access to our products. To contact us by Next Generation Text on any of the numbers listed in this handbook just prefix the number listed with 18001. For example, our team of Personal Advisers can be contacted by Next Generation Text on 18001 0345 600 7696. For Health queries and information

Contents

1 Quick-start guide to your cover

This section explains the basics of the cover your company 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.

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 the **plan**.

We, us and our

When we use we, us or our, we mean Health-on-Line on behalf of AXA PPP healthcare, who is the insurance company who underwrite this product.

1.1 > Why it's important to use hospitals or day-patient units in the hospital list

If you have **treatment** at a hospital or **day-patient unit** that's not in the **hospital list** but is still recognised by AXA PPP healthcare, we will only pay 60% of the charges that AXA PPP healthcare would normally pay to that hospital or **day-patient unit**. You will be responsible for paying the remaining charges.

If you have **treatment** at a hospital or **day-patient unit** that's not in the **hospital list** and is not recognised by AXA PPP healthcare, you will be responsible for paying the full amount of the charges.

1.2 > Why it's important to use Priority Health specialists

If your **treatment** is provided by a **specialist** who is not a **Priority Health specialist** but who is recognised by AXA PPP healthcare, we will only pay 60% of the charges that would normally be paid by AXA PPP healthcare. You will be responsible for paying the remaining charges.

If your **treatment** is provided by a specialist who is neither a **Priority Health specialist** nor recognised by AXA PPP healthcare, you will be responsible for paying the full amount of the charges.

Not all specialists and specialties are available at all private hospitals.

We strongly recommend that you call us on 0345 600 7696 before you arrange a consultation or treatment so that we can check that you're covered.

1.3 > Your core cover – applies to all

This table shows you the core cover the **plan** gives you.

Core cover table		
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 **private hospital** or **day-patient unit** listed in the **hospital list**	Including fees for **in-patient** or **day-patient**: • accommodation • **diagnostic tests** • using the operating theatre • nursing care • drugs • dressings • radiotherapy and chemotherapy • physiotherapy • surgical appliances that the **specialist** uses during **surgery**. » **For details, see 3.8**
Specialist fees	✓ No **yearly** limit so long as you use a **Priority Health specialist**	Includes fees for: • surgeons • anaesthetists • physicians. » **For details, see 3.6**
Hospital 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 the **plan** and be 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 **private 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 3.8**

Other cover		
Ambulance transport	✓ Paid in full	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**.
Cash payment if you have chemotherapy or radiotherapy free on the NHS	✓ £50 a day up to £2,000 a **year**	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 the **plan**. If the **plan** has an excess, you do not have to pay this if having this **treatment**. » **For details, see 4.1**
Health at Hand	✓ Direct access to healthcare experts 24/7	» **For details, see 1.6**

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.

1.4 > Extra cover from Options

The following tables show you what cover your Options give you.
The **plan** guide shows which Options you have.

Out-patient Options

Standard Out-patient Option table

Cover applies when you're an **out-patient**

Specialist consultations	✓ Up to two consultations a **year**	We pay for consultations in the order we assess the claims, which may not be the same order that you had the consultations. So the consultations we pay for may not be the first two that you had. » **For details, see 3.7**
Diagnostic tests when your **specialist** refers you	✓ No **yearly** limit	
CT, MRI or PET scans	✓ Paid in full at a **scanning centre**, or hospital listed as a **scanning centre** in the **hospital list**	A **specialist** must refer you. CT = Computerised Tomography MRI = Magnetic Resonance Imaging PET = Positron Emission Tomography

Enhanced Out-patient Option table

Cover applies when you're an **out-patient**

Specialist consultations **Diagnostic tests** when your **specialist** refers you **Practitioner** fees when your **specialist** refers you	✓ A combined **yearly** limit of £1,000	**Practitioners** are **nurses**, dieticians, orthoptists and speech therapists. » **For details, see 3.7**
CT, MRI or PET scans	✓ Paid in full at a **scanning centre**, or hospital listed as a **scanning centre** in the **hospital list**	A **specialist** must refer you. CT = Computerised Tomography MRI = Magnetic Resonance Imaging PET = Positron Emission Tomography

Full Out-patient Option table

Cover applies when you're an **out-patient**

Specialist consultations **Diagnostic tests** when your **specialist** refers you **Practitioner** fees when your **specialist** refers you	✓ No **yearly** limit	**Practitioners** are **nurses**, dieticians, orthoptists and speech therapists. » **For details, see 3.7**
CT, MRI or PET scans	✓ Paid in full at a **scanning centre**, or hospital listed as a **scanning centre** in the **hospital list**	A **specialist** must refer you. CT = Computerised Tomography MRI = Magnetic Resonance Imaging PET = Positron Emission Tomography

Therapies Option table

Fees for **out-patient treatment** by **physiotherapists**, **osteopaths** or **chiropractors**	✓ A combined limit of £500 a **year** that can include: • up to an overall maximum of 10 sessions in a **year** when your **GP** refers you • further sessions (as long as we agree them first) when your **specialist** refers you	» **For details, see 3.7**

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.

Mental Health Option table

If you're an **in-patient** or **day-patient**		
Private hospital and **day-patient unit** fees for psychiatric **treatment**	✓ Paid in full for up to 30 days a **year**	So long as you use a hospital or **day-patient unit** in the **hospital list**. Including fees for: • accommodation • **diagnostic tests** • drugs. » **For details, see 3.8**
Specialist fees for psychiatric **treatment**	✓ No **yearly** limit so long as you use a **Priority Health specialist**	» **For details, see 3.7**
If you're an **out-patient**		
Specialist consultations for psychiatric **treatment**	✓ A combined limit of £1,000 a **year**	» **For details, see 3.7**
Psychiatric **treatment** by **psychologists** and **cognitive behavioural therapists**		

Extra Care Option table

Nurse to give you chemotherapy or antibiotics by intravenous drip at home	✓ Paid in full	We will pay for **treatment**: • at home • somewhere else that is appropriate. We will pay for a **nurse** to give you either of the following by intravenous drip: • chemotherapy to treat **cancer** • antibiotics. This is so long as: • we have agreed the **treatment** beforehand • you would otherwise need to be admitted for **in-patient** or **day-patient treatment** • the **nurse** is working under the supervision of a **specialist** • the **treatment** is provided through a healthcare services supplier that we have a contract with for this kind of service.
Cash payment when you have free **treatment** under the NHS	✓ £50 a night up to £2,000 a **year**	We pay this when: • you are admitted for **in-patient treatment** before midnight • we would have covered your **treatment** if you had had it privately. If you have an excess, we will not take this off this cash payment. 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.
Oral **surgery**	✓ Paid in full in a **private hospital** or **day-patient unit** in the **hospital list**	So long as your dentist refers you, we will pay for: • reinserting your own teeth after a trauma • surgical removal of impacted teeth, buried teeth and complicated buried roots • removal of cysts in the jaw (sometimes called enucleation). » **For details, see 4.32**

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.

Chiropody and podiatry fees	✓ Up to £150 a **year**	So long as your chiropodist or podiatrist is qualified. If you have an excess, you do not have to pay the excess if having this **treatment**. » **For details, see 4.4**

Dentist and Optician Cashback Option table		
Dentist fees	✓ 80% of your dentist's fees, up to £400 a **year**	If you have an excess, you do not have to pay the excess if you claim for dentist fees. » **For details, see 4.32**
Optician fees	✓ 80% of the cost of prescribed glasses and contact lenses, up to £200 a **year**	We will pay this so long as the glasses or lenses are used to correct your vision. If you have an excess, you do not have to pay the excess if you claim for optician fees. » **For details, see 4.18**
Eye test	✓ Up to £25 a **year** for an eye test	If you have an excess, you do not have to pay the excess if you claim for an eye test. » **For details, see 4.18**

Extra Cancer Cover Option table		
This cover extends the **cancer** cover you have with your core cover and any extra **out-patient** cover you have		» **For details, see 4.1**

Private GP Cover Option		
Fees for visits to a private **GP** for consultations	✓ Up to £500 a **year**	
Doctor@Hand consultations	✓ Up to five consultations a **year** with a Doctor@Hand **GP**	Access to a **GP** service for online, video or telephone consultations. You need to register for this service, please go to: health-on-line.co.uk/DAH You will need to pay for your consultations and claim the costs back from us. If you have an excess, we will not take this off this benefit.

1.5 > The main things we don't cover

Like all health insurance policies, 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 the plan 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 the plan doesn't cover?

The plan does not cover	For more information	Notes
✗ Routine pregnancy and childbirth	» **For details, see 4.24 or call us on 0345 600 7696**	Few health insurance policies 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 3.3**	The **plan** is designed to cover necessary **treatment** of new **medical conditions** that arise after you join.

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.

✕ **Treatment** of ongoing, recurrent and long-term conditions (**chronic conditions**)	» For details, see 3.5	

Key things that may not be covered depending on the Options you've chosen

The membership statement, which is part of the **plan** guide, shows you which Options you have.

Your Options	Your cover
If you do not have an out-patient Option	✕ You do not have any cover for **out-patient diagnostic tests** or consultations ✕ You do not have any cover for **out-patient** computerised tomography (CT), magnetic resonance imaging (MRI), and positron emission tomography (PET).
If you do not have the Therapies Option	✕ You do not have cover for fees for physiotherapists, osteopaths or chiropractors
If you do not have the Mental Health Option	✕ You do not have cover for any psychiatric **treatment**
If you do not have the Dentist and Optician Cashback Option	✕ You do not have cover for dentists' or opticians' fees

☎ If you have any questions about your cover please call us on 0345 600 7696.

1.6 > Help with medical questions or health worries – Health at Hand

With Health at Hand you can speak to a healthcare professional whenever you have a medical question or health worry.

The 24-hour Health at Hand helpline is staffed by many of the health professionals you would find working at a local health centre, including nurses, counsellors, midwives and pharmacists. They can help you whether you want to talk about a specific health worry, medication or treatment, or if you just need guidance and reassurance.

Call 0800 003 004

The helpline is open 24 hours a day, 365 days a year. Please note that our pharmacists and midwives are here from 8am to 8pm Monday to Friday, until 4pm on Saturday, and until 12pm on Sunday.

If calling from outside the UK, please call +44 1737 815 197.

Health at Hand does not diagnose or prescribe, and is not designed to replace your GP. Any information you share with us is confidential and will not be shared with our claims department or other parts of our business.

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. This means our Fast Track Appointments service can help you find a suitable specialist 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 Call us on 0345 600 7696 before you see the specialist

Call us as soon as you've seen your GP. It's important you call 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 to pay for treatment that you're not covered for.

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.

You can also use our Fast Track Appointments if you would like a second opinion from another specialist. Simply call us and we can discuss the options with you.

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. That's why, with 'Working Body', we've made it easy for you to speak to our team of experts.

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 us. We'll check what cover you have and you'll get a call back by the end of the next working day to arrange a free telephone assessment.

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.

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 we pay 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 have private medical insurance?

Yes you must tell the place where you have your **treatment** that you have private medical insurance. 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 costs, minus any excess. Please send the original receipts from the **specialist** or hospital to Health-on-Line Claims Department, PO Box 503, Tunbridge Wells, Kent TN2 9RT.

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

What should I do if I need further treatment?

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

The information we may need when you make a claim

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

Usually, this all happens very quickly. However, sometimes we need more detailed medical information, including access to your medical records.

What does 'more detailed 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 the **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** starts (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 the **plan** 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 be able to use one of our **Priority Health specialists** knowing that we'll pay for **treatment** you're covered for.
- However, if you would prefer to use a specific specialist, or if your **GP** has already named a specialist, simply contact 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 cost 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 contact us, as we may be able to cover this.

✓ **Extra cover if you have the Extra Care Option**

If you have the Extra Care Option, you may be able to claim a cash payment for each night you spend in an NHS hospital.

» For more details, see the Extra Care Option table on page 6

3 How the plan works

How the plan works

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

Any questions?

If you're unsure how something works, just call us on 0800 587 0957 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 0345 600 7696 first 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

The **plan** does not cover primary care services, such as any services that could be provided by **GP's**, dentist 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.

✓ **Extra cover if you have the Dentist and Optician Cashback Option**

If you have the Dentist and Optician Cashback Option, some services provided by dentists and opticians will be covered.

» For more details, see the Dentist and Optician Cashback Option table

✓ **Extra cover if you have the Private GP Cover Option**

If you have the Private GP Cover Option you have some cover for private GP consultations and access to Doctor@Hand.

» For more details, see the Private GP Cover Option table

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
- is of an **acute condition** (for details see 3.5)
- is **conventional treatment** (for details see 3.3)
- is not preventative (for details see 4.14)
- does not cost more than an equivalent **treatment** that is as likely to deliver a similar therapeutic or diagnostic outcome
- 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 3.5 and 3.3.

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 drugs, **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 effective for 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.

» **To check whether we will agree to cover a treatment, please call us on 0345 600 7696 before you start treatment**

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 **Priority Health 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
- take place in the **UK**
- 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 equivalent **conventional treatment** we will pay the cost of the **unproven treatment**.
- 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 **Priority Health specialist** and hospital in the **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**
- support you with additional information and questions for your **specialist**, before you have **treatment**
- agree what costs (if any) we will meet, see important points below. All **unproven treatment** must be agreed by us in writing, so you are clear before having **treatment** of any shortfall you may have to pay to the hospital and/or the **specialist**.

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 0345 600 7696 before you start treatment**

3.4 > How the plan 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 **company** has chosen and what you told us about your medical history when you joined.

Am I covered 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 pre-existing condition

A **pre-existing condition** is any disease, illness or injury that:

- you have received medication, advice or **treatment** for 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 membership statement, you'll see a section called 'Your cover for existing conditions'. This will tell you which underwriting terms you joined on. Here are the options:

- Fully underwritten (or full medical underwriting)
- Continuing medical exclusions
- Medical history disregarded
- Moratorium (also known as Two Year Watch and Wait).

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 contact 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 membership statement – please check this carefully. For example, you may not have cover for something specific if you have had that condition in the past. Your statement will also show whether we can remove the exclusion after a period of time.

Continuing 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 membership statement – please check this carefully. For example, you may not have cover for something specific if you have had that condition in the past. Your statement will also show whether we will remove the exclusion after a period of time.

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 membership statement 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 plan, or for a newborn baby who was added to the **plan**.

Moratorium (also known as Two Year Watch And Wait)

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 12 months in a row since you joined that have been **trouble-free** from that condition.

If you joined us from another health insurer or from a company plan, 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. Your membership statement will show more details about how your particular moratorium works.

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 any medical practitioner, including but not limited to a practitioner, physiotherapist, osteopath, optician or dentist.

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

Whichever form of underwriting you joined on, we may have asked you some medical questions before agreeing your cover. We worked out your terms or your premium based on your answers. If you did not answer fully or accurately, even if this was by accident, we 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 or previous condition, whether you had **treatment** for them or not
- any previous **medical condition** that recurs
- 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 the plan works with conditions that last a long time or come back (chronic conditions)

Like most health insurance, the **plan** 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 the plan cover me for treatment of conditions that last a long time or come back (chronic conditions)?

The **plan** does not cover you for conditions that:

- come back (recur)
- are likely to continue for a while
- are long-term.

However, the **plan** 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**
- any **treatment** that only offers temporary relief of your symptoms, rather than dealing with the underlying condition
- 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' definitions 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?

We treat **cancer treatment** in a different way to other long-term conditions, and cover more long-term **treatment**.

» There is a full explanation of how we cover cancer treatment in section 4 of the handbook

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

✓ **Extra cover if you have an out-patient Option**

If you have an out-patient Option, we will 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 **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 do not have an out-patient Option, we will not cover long-term monitoring, consultations, check-ups, scans or examinations related to your heart condition.

Whether you have an out-patient Option or not, we will still be here to support you if you are diagnosed with a heart condition. At any time, 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?

✕ If you do not have an out-patient Option, your cover for **treatment** of **chronic conditions** is likely to be limited, as most of the **treatment** happens when you are an **out-patient**. However, if your condition flares up or you develop complications, we will cover **in-patient treatment** to take your condition back to its controlled state.

✓ **Extra cover if you have an out-patient Option**

If you have an out-patient Option, 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**.

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).

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.

» **For more information about how we cover treatment for chronic conditions, including some examples of how our cover works, please see Health-on-Line.co.uk**

3.6 > Paying the specialists and practitioners that treat you – cover for all

Does the plan cover the full fees charged by specialists?

When your **treatment** is covered and it is provided by a **specialist** who is a **Priority Health specialist**, we will pay the charges in full. 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 **Priority Health specialist**.

If your **treatment** is provided by a **specialist** who is not a **Priority Health specialist** but who is recognised by AXA PPP healthcare, we will pay 60% of the charges that would normally be paid by AXA PPP healthcare. You will be responsible for paying the remaining charges.

If your **treatment** is provided by a **specialist** who is neither a **Priority Health specialist** nor recognised by AXA PPP healthcare, you will be responsible for paying the full amount of the charges.

Not all specialists and specialties are available at all private hospitals.

We strongly recommend that you call us on 0345 600 7696 before you arrange a consultation or treatment so that we can check that you're covered.

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 they are a **Priority Health specialist**.

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 not a **Priority Health specialist** but is recognised by AXA PPP healthcare we will pay 60% of the fees that would normally be paid by AXA PPP healthcare. You will be responsible for paying the remaining charges.

If your anaesthetist is neither a **Priority Health specialist** nor recognised by AXA PPP healthcare, you will be responsible for paying the full amount of the charges.

Fast Track Appointments

Our Fast Track Appointments team can find up to three suitable specialists for you to choose from, and even book your appointment for you. Just call us on 0345 600 7696.

3.7 > Paying the specialists and practitioners that treat you – extra cover that depends on your Options

Who will be paid under out-patient Options?

✓ **Extra cover if you have an out-patient Option**

If you have an out-patient Option, 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.

This includes remote consultations by telephone or via a video link. These will be covered under the **out-patient** consultation benefit if AXA PPP healthcare have agreed with the **specialist** that he/she is recognised to carry out remote consultations for members.

» For more about how we pay specialists, see the Core cover table on page 4 and section 3.7

✓ **Extra cover if you have the Enhanced or Full Out-patient Option**

If you have either the Enhanced or Full Out-patient Option, we will also pay for the **out-patient treatment** you need with a **practitioner**. By **practitioner** we mean a:

- **nurse**
- dietician
- orthoptist
- speech therapist.

We will pay so long as a **specialist** refers you.

We pay **practitioners** in full if they are a **Priority Health specialist**. Please contact us before you start **treatment** so we can confirm whether we will pay your **practitioner** in full.

If you use a **practitioner** who is recognised by AXA PPP healthcare but who is not a **Priority Health specialist** we will only pay 60% of the charges normally paid by AXA PPP healthcare. You will need to pay the rest yourself.

If you use a practitioner that AXA PPP healthcare do not recognise, we will not pay for your **treatment**.

Who will be paid under the Therapies Option?

✓ **Extra cover if you have the Therapies Option**

If you have the Therapies Option, we will pay **out-patient treatment** fees for any of the following that we recognise so long as your **treatment** is covered and the Working Body team, your **GP** or **specialist** refers you:

- **physiotherapists**
- **osteopaths**
- **chiropractors**.

If your **GP** refers you for the **treatment**, you are covered for an overall maximum of ten sessions in a **year**.

If your **specialist** refers you, we may agree to more sessions, but will need to agree them in writing first.

We pay **physiotherapists**, **osteopaths** and **chiropractors** in full if they are a **Priority Health specialist**. All **physiotherapists**, **osteopaths** and **chiropractors** used by our Working Body team will be **Priority Health specialists**. Please contact us before you start **treatment** so we can confirm whether we will pay your therapist in full.

If you use a **physiotherapist**, **osteopath** or **chiropractor** who is recognised by AXA PPP healthcare but who is not a **Priority Health specialist** we will only pay 60% of the charges normally paid by AXA PPP healthcare. You will need to pay the rest yourself.

If you use a physiotherapist, osteopath or chiropractor that AXA PPP healthcare does not recognise, we will not pay for your **treatment**.

Who will be paid under the Mental Health Option?

✓ **Extra cover if you have the Mental Health Option**

If you have the Mental Health Option, we will pay for covered **in-patient** or **day-patient** psychiatric **treatment**, including **specialist** fees, as shown in the Mental health Option table on page 6.

We will pay for **out-patient treatment** by any of the following:

- a mental health **specialist**
- a **cognitive behavioural therapist**, so long as a **specialist** refers you
- a **psychologist**, so long as a **specialist** refers you.

We pay **specialists**, **cognitive behavioural therapists** and **psychologists** in full if they are a **Priority Health specialist**. Please contact us before you start **treatment** so we can confirm whether we will pay your therapist in full.

If you use a **specialist**, **cognitive behavioural therapist** or **psychologist** who is recognised by AXA PPP healthcare but who is not a **Priority Health specialist** we will only pay 60% of the charges normally paid by AXA PPP healthcare. You will need to pay the rest yourself.

If you use a specialist, cognitive behavioural therapist or psychologists that AXA PPP healthcare do not recognise, we will not pay for your **treatment**.

Not all specialists and specialties are available at all private hospitals.

We strongly recommend that you call us on 0345 600 7696 before you arrange a consultation or treatment so that we can check that you're covered.

3.8 > Paying the places where you're treated – cover for all

Where can I have treatment?

If your **treatment** is covered by the **plan**, 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 the **hospital list**:

- a hospital
- a **day-patient unit**.

If your **treatment** is covered by the **plan**, but you have the **treatment** in a facility not listed in the **hospital list**, we'll pay 60% of the fees AXA PPP healthcare would pay that facility.

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 from specialists, please also see sections 3.6 and 3.7**

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

- **out-patient treatment**
- intensive care
- cataract **surgery**
- oral **surgery** as part of the Extra Care Option.

Where can I have out-patient treatment?

The cover you have for **out-patient treatment** depends on whether you have an out-patient Option.

We will pay fees at an **out-patient facility** in full. This is so long as AXA PPP healthcare have an agreement with the **facility** to provide **out-patient treatment** to Priority Health members. We will pay these so long as your **treatment** is covered by the **plan**, and a **specialist** is overseeing it.

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

If our agreement does not cover Priority Health members we will only pay 60% of the fees AXA PPP healthcare normally pay and you will need to pay the rest yourself.

There are some **out-patient** facilities that AXA PPP healthcare does not have an agreement with at all. If you have **treatment** at one of those facilities you will be responsible for paying the full amount of those charges.

What about intensive care?

If you have private intensive care **treatment** in a **private 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 the **plan**
- you or your next of kin have asked for you to have the intensive care **treatment** privately.

What about treatment on the NHS?

✕ If you do not have the Extra Care Option, we do not pay anything else when you have **treatment** on the NHS.

✓ **Extra cover if you have the Extra Care Option**

If you have the Extra Care Option, and have free **treatment** on the NHS that would have been covered by the **plan**, we will pay you a cash payment. This includes **treatment** in an NHS Intensive Therapy or Intensive Care unit.

» **For more details, see the Extra Care Option table on page 6**

Does the 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.

Not all specialists and specialties are available at all private hospitals.

We strongly recommend that you call us on 0345 600 7696 before you arrange a consultation or treatment so that we can check that you're covered.

3.9 > General restrictions

High charges

We will continue to pay the fees of **Priority Health specialists** in full so long as they continue to charge fees within the range that is usual for the **treatment** they provide.

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 **specialist** in our fee-approved category
- a **physiotherapist**
- an **osteopath**
- a **chiropractor**
- a **cognitive behavioural therapist**
- a **psychologist**
- 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

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 the plan – even if you don't need to claim for it at the moment – please just give us a call on 0345 600 7696. 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 0345 600 7696 and we'll be very glad to help explain anything that's unclear.

If you want to make a claim, please call us on 0345 600 7696 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.

About your cover for cancer treatment

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 3.3**

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.

Cover for all

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

If you have **day-patient** or **out-patient** radiotherapy or chemotherapy on the NHS, and the **plan** would have covered that **treatment**, we will make a cash payment to you of £50 a day, up to a maximum of £2,000 a **year**.

✓ Extra cover if you have the Extra Care Option

If you have the Extra Care Option, 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).

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**.

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. This will also help you to compare the cover you get as standard with the cover you get with the Extra Cancer Cover Option.

Place of treatment	If I have the Extra Cancer Cover Option, am I covered?	If I do not have the Extra Cancer Option, am I covered?
Private hospitals, day-patient units or scanning centres listed in the **hospital list**.	✓ Yes	✓ Yes
Chemotherapy by intravenous drip at home.	✓ Yes	✓ If you have the Extra Care Option. » **For more details, see the Extra Care Option table on page 6.**
Treatment at a hospice.	✓ We will make a donation of £100 for every night you spend in a hospice or have hospice at home care.	✗ We will not make a donation.
Diagnostic	If I have the Extra Cancer Cover Option, am I covered?	If I do not have the Extra Cancer Option, am I covered?
Whether you are an **in-patient**, **day-patient** or **out-patient**		
Surgery as shown below under '**Surgery**'.	✓ Yes	✓ Yes
CT, MRI and PET scans as an **in-patient** or **day-patient**.	✓ Yes	✓ Yes

CT, MRI and PET scans as an **out-patient**.	✓ Yes	✓ If you have an out-patient Option. ✗ If you do not have have an out-patient Option.
Genetic testing to work out whether you have a genetic risk of developing cancer.	✗ No	✗ No
Genetic testing proven to help choose the best chemotherapy.	✓ Yes	✓ Yes
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	✓ Yes
Diagnostic tests as an **in-patient** or **day-patient.**	✓ Yes	✓ Yes
If you're an **out-patient**		
Specialist consultations with the **specialist** treating your **cancer** when you are an **out-patient**.	✓ Yes If you have an **out-patient** Option, the consultations will not come out of your **out-patient** limit. If the consultations are before your diagnosis, consultations are covered as part of your overall **out-patient** limit. » **For more details, see the out-patient Option tables on page 5.**	✗ If you do not have an out-patient Option: no. ✓ If you have an out-patient Option: yes.
Diagnostic tests as an **out-patient** when ordered by the **specialist** treating your **cancer**.	✓ Yes If you have an **out-patient** Option, the tests will not come out of your **out-patient** limit. If the tests are before your diagnosis, consultations are covered as part of your overall **out-patient** limit. » **For more details, see the out-patient Option tables on page 5.**	✗ If you do not have an out-patient Option: no. ✓ If you have an out-patient Option: yes.

Surgery	If I have the Extra Cancer Cover Option, am I covered?	If I do not have the Extra Cancer Option, 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 that **treatment** has been shown to be effective. » **See page 38 for how we define surgery.** » **See page 11 for more about effective treatment.**	✓ Yes	✓ Yes

Preventative	If I have the Extra Cancer Cover Option, am I covered?	If I do not have the Extra Cancer Option, am I covered?
Preventative **treatment**, such as: Screening when you do not have symptoms of **cancer**. For example, if you had a screen that showed 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 mastectomy). Vaccines to prevent **cancer** developing or coming back – such as vaccinations to prevent cervical **cancer**.	✕ No	✕ No
Drug therapy	If I have the Extra Cancer Cover Option, am I covered?	If I do not have the Extra Cancer Option, 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 0345 600 7696 and we can talk you through this.	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 0345 600 7696 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 us once you know your **treatment** plan.	✓ Yes We cover these drugs for up to one year, or for the time allowed by the licence – whichever is shorter 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. We start the time limit from when you first started **treatment** that we paid for. Because drug licences change, this means that the drugs we cover will change from time to time. Please call us once you know your **treatment** plan.

Unproven drugs.	If you've been invited to take part in a randomised clinical trial approved by an appropriate ethics committee, we will pay for your stay in hospital, including your specialist's fees while you are receiving the clinical trial drug. You need to call us before **treatment** so we can agree cover and costs in writing. There will be information we need you to provide before we can agree costs. For example we will need you to provide us with a copy of your trial acceptance forms.	✗ Not covered.
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 that is covered by the **plan**.	✓ We will cover these for up to three months as long as you have them at the same time as you are having chemotherapy or biological therapy to kill **cancer** cells that is covered by the **plan**.
Drugs for treating conditions secondary to **cancer**, such as erythropoietin (EPO).	✓ Yes, while you are having chemotherapy that is covered by the **plan**.	✓ Yes, while you are having chemotherapy that is covered by the **plan**.

Radiotherapy	If I have the Extra Cancer Cover Option, am I covered?	If I do not have the Extra Cancer Option, am I covered?
Radiotherapy including when it is used to relieve pain.	✓ Yes	✓ Yes
Palliative and end of life care	If I have the Extra Cancer Cover Option, am I covered?	If I do not have the Extra Cancer Option, 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.	✓ 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.	✓ £100 a night	✗ No

Monitoring	If I have the Extra Cancer Cover Option, am I covered?	If I do not have the Extra Cancer Option, 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.	✗ If you do not have an **out-patient** Option: no. ✓ If you have an **out-patient** Option: yes, for 10 years from your last **surgery**, chemotherapy or radiotherapy for that **cancer** 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	✗ 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	✓ Yes

Limits	If I have the Extra Cancer Cover Option, what limits are there on **treatment** under the **plan**?	If I do not have the Extra Cancer Cover Option, what limits are there on **treatment** under the **plan**?
Time limits on **cancer treatment**. The **plan** covers you while you are having **treatment** to kill **cancer** cells.	None	There are some time limits on drug **treatment** for **cancer**. For example, we will cover drug **treatment** to kill **cancer** cells (such as biological therapies or chemotherapy) for up to one year, and bone strengthening drugs or hormone therapy by injection for up to three months as described in this table.
Money limits on **cancer treatment**.	No specific limits – the same rules apply to your **cancer treatment** as for any other **treatment**.	No specific limits – the same rules apply to your **cancer treatment** as for any other **treatment**.

Other benefits	If I have the Extra Cancer Cover Option, what other benefits are there?	If I do not have the Extra Cancer Cover Option, what other benefits are there?
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 cost of finding a donor. » **See page 27 for more about this.**	✓ Yes	✓ Yes
The cost of wigs or external prostheses needed because of **cancer** whilst you are having treatment to kill **cancer** cells.	✓ Up to £150 a **year** for wigs and up to £5,000 a **year** for prostheses.	× No

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, podiatry and foot care

Our cover for chiropody, podiatry and foot care depends on whether you have the Extra Care Option.

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

✓ **Extra cover under the Extra Care Option**

If you have the Extra Care Option, we will cover fees for chiropody or podiatry up to £150 per **year**, so long as your chiropodist or podiatrist is qualified.

» **For more details, see the Extra Care Option table on page 6**

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 the **plan**, 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**.
- **Treatment** that is connected to previous cosmetic **treatment** or cosmetic **surgery**.

» **See also 4.25**

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 don't cover drugs, dressings or prescriptions that:

- you are given to take home after you have had **in-patient**, **day-patient** or **out-patient treatment**
- could be prescribed by a **GP** or bought without a prescription
- 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 of this handbook.**

4.10 > External prostheses or appliances

We do not cover the costs of providing or fitting external prostheses or appliances, such as crutches, joint supports, and contact lenses.

✓ Extra cover if you have the Extra Cancer Cover Option

If you have the Extra Cancer Cover Option, we will pay towards the cost of wigs or external prostheses needed because of **cancer** whilst you are having **treatment** to kill **cancer** cells.

4.11 > Fat removal

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

4.12 > Gender re-assignment 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**
- psychotherapy or similar services
- 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
- routine preventative examinations and check-ups
- genetic screening tests to check whether:
  - you have a **medical condition** when you have no symptoms
  - you have a genetic risk of developing a **medical condition** in the future
  - 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
- any other preventative **treatment** or screening tests to see whether you have a **medical condition** if you do not have any symptoms
- 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 the **plan**.

☎ If you're unsure whether your treatment is preventative or not, please call us on 0345 600 7696 before going ahead with the treatment.

4.14 > GP and primary care services

✗ If you do not have the Dentist and Optician Cashback Option, we do not cover any fees for services that a GP or dentist could normally carry out, or any other primary care services.

✗ We do not pay for prescriptions, appliances or other ancillary services provided by GPs.

✗ We do not pay for membership fees (sometimes known as subscription fees) for GP services.

✓ **Extra cover if you have the Dentist and Optician Cashback Option**

If you have the Dentist and Optician Cashback Option, we will pay towards dentists' and opticians' fees but not fees for services that a GP could normally carry out or any other primary care services.

✓ **Extra cover if you have the Private GP Cover Option**

If you have the Private GP Cover Option, you have cover for private GP consultations and access to Doctor@Hand for online, video and telephone consultations as shown in the Private GP Cover Options table.

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
- investigations into miscarriage
- assisted reproduction
- 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

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 long sightedness, short sightedness or astigmatism.

✓ **Extra cover if you have the Dentist and Optician Cashback Option**

If you have the Dentist and Optician Cashback Option, we will pay towards the cost of eye tests, prescribed glasses and prescribed contact lenses.

» For more details, see the Dentist and Optician Cashback Option table on page 7

What is not covered under this Option?

We will not pay towards the cost of:

- contact lens check ups
- contact lens solutions
- repairs to non-prescribed glasses
- new frames
- replacements that you need because of accidental damage
- non-prescribed items that you buy as part of an eye care contract scheme.

If you have an eye care contract scheme and want to claim for anything that you have paid for as part of that scheme, please ask your optician for a receipt showing the cost of all the items you have paid for under the scheme.

What you need to claim cashback

If you want to claim cashback under this Option, please ask your optician for full receipts for everything you wish to claim for. We cannot pay any claims without a receipt. Then call us on 0345 600 7696 and we will explain what to do.

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 whether you have the Mental Health Option.

✗ If you do not have the Mental Health Option, we do not cover any **treatment** of psychiatric illness.

✓ **Extra cover under the Mental Health Option**

If you have the Mental Health Option, we will cover your **treatment** for psychiatric illness.

This includes:

- **in-patient** and **day-patient treatment** in hospital
- **out-patient treatment**.

» For more details, see the Mental Health Option table on page 6

All your other **plan** rules still apply to your cover.

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 under the Option?

Even if you have the Mental Health Option, we do not cover any **treatment** connected in any way to:

- an injury you inflicted on yourself deliberately
- a suicide attempt
- alcohol abuse
- drug or substance abuse.

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.

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 a 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

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

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 normal checks or other interventions, such as monitoring and screening, that you will have during pregnancy and birth. However, if you develop a **medical condition** while pregnant or giving birth, we may cover it.

What is covered?

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

- ectopic pregnancy (pregnancy where the embryo or foetus grows outside the womb)
- hydatidiform mole (abnormal cell growth in the womb)
- retained placenta (afterbirth retained in the womb)
- placenta praevia
- eclampsia (a coma or seizure during pregnancy and following pre eclampsia)
- diabetes (If you have exclusions because of your past medical history related to diabetes, then you will not be covered for any **treatment** for diabetes during pregnancy)
- 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 0345 600 7696 to check what you are covered for before starting any private **treatment**.

☎ If you have a baby, we can often add them to the **plan** 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 0345 600 7696 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 the **plan**. We will do this so long as:

- you had continuous cover with us before the accident or **surgery** happened
- we agree the method and cost of the **treatment** in writing 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 0345 600 7696 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 4.7

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 is part of **treatment** that is covered by the **plan**.
- A **specialist** in rehabilitation is overseeing your **treatment**.
- You have your **treatment** in a rehabilitation hospital or unit that is included in the **hospital list**.
- The **treatment** can't be carried out as a **day-patient** or an **out-patient**, or in another suitable location.
- We have agreed the costs before you start rehabilitation.

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

☎ If you need rehabilitation, please call us on 0345 600 7696, 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
- receive a grant or sponsorship (we do not count travel costs in this), or
- are competing for prize money.

4.31 > Sterilisation

We do not cover:

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

4.32 > Teeth and dental conditions

Our cover for treating teeth and dental conditions depends on whether you have the Extra Care Option or Dentist and Optician Cashback Option. If you do not have either Option, the **plan** will not cover dental problems or any routine dental care.

Cover for all

You do not have cover for treating dental problems or any routine dental care including oral **surgery**, this also means we will not pay any fees for dental **specialists**, such as orthodontists, periodontists, endodontists or prosthodontists.

✓ **Extra cover if you have the Extra Care Option**

If you have the Extra Care Option, 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
- removing impacted teeth, buried teeth and complicated buried roots
- removal of cysts in the jaw (sometimes called enucleation).

✓ **Extra cover if you have the Dentist and Optician Cashback Option**

If you have the Dentist and Optician Cashback Option, we will pay towards your dentist's fees, as shown in the table on page 7. We will pay for fees that you have paid directly to a dentist or dental hygienist, so long as they are registered with the General Dental Council.

If you have a dental care contract scheme (such as Denplan), we will not pay for any premiums you have paid for this scheme.

What you need to claim cashback

If you want to claim cashback under this Option, please ask your dentist for full receipts for everything you wish to claim for. We cannot pay any claims without a receipt. Then call us on 0345 600 7696 and we will tell you what to do next.

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 or for treatment if you live outside the **UK**. If you are going to live outside of the **UK** please call us on 0800 587 0957 as you may be able to set up a new plan with our international team.

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 six 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 the **plan**.

» Please see 3.5

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 the plan

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 employer. Depending on your agreement with your employer, there may be restrictions on when you can add **family members**.

☏ Please contact your group secretary 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 contact us 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 the **plan**. 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

The membership statement 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 an excess on the **plan**, you can see the amount on the membership statement in the **plan** guide. Here is how excesses work:

- We will take your excess off the amount covered by the **plan** for the first claim for each person in each **plan 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 the **plan** claim, we will take the excess off both their claims.
- We only take off the excess once per person per **plan 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 **plan year**. This means that if you incur costs during this **plan year**, we will take the excess off what we pay for your claim. If you then incur more costs in the next **plan 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 587 0957.

» 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
- If you have the Extra Care Option: NHS cash benefit or chiropody.
- If you have the Dentist and Optician Cashback Option: any claim for dentist's fees, optician's fees or eye tests
- If you have the Extra Cancer Cover Option: any claim for wigs or hospice donations
- If you have Private GP Cover Option: Doctor@Hand consultations.

The excess will apply to all other benefits, including the 'Fees for visits to a private **GP** for consultations' benefit if you have the Private GP Cover Option.

If you would like to change or add an excess

Adding an excess, or increasing the amount of your excess, helps to lower your premium.

If you would like to change or add an excess, you can normally do this:

- within 14 days from when you receive the **plan** documents
- when you renew.

Call us on 0800 587 0957 and we will set this up for you.

An example of how we work out the excess

Excesses can be complicated, so we've included an example of how it works here.

Situation:

- Ann has the Enhanced Out-patient Option, which has a limit of £1,000 for **out-patient treatment** (as shown in the table on page 5)
- She also has an excess of £100.

Here's how it works:

1 Ann has a medical problem that is covered by her Option. She claims for £700 for **out-patient treatment** (her first claim for the **year**).

2 We apply the £100 excess, so Ann pays the first £100 of the claim.

3 We then pay the remaining £600 directly to the hospital.

4 We take the whole £700 cost of the claim off Ann's £1,000 limit for **out-patient treatment** (not just the £600 that we paid). So she now has £300 left for **out-patient treatment** for the rest of the **year**.

5 A month later, but in the same **plan year**, Ann needs some more **out-patient treatment** that's covered by her Option. This costs £450.

Ann doesn't need to pay any excess, because she has already paid her full excess in this **plan year**. But she only has £300 left from her Enhanced Out-patient Option limit.

So we'll pay £300 towards the cost. Ann will need to pay the remaining £150 herself to the hospital.

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 the **plan**.

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 keep your current **plan** and you will not be able to make any claims. Please call us on 0800 587 0957 to discuss your options.

Can I stay on the same plan if I move abroad?

If you go to live abroad, you cannot stay on the same healthcare insurance **plan**. However, you may be able to join an AXA PPP International plan. Please call us on 0800 587 0957 to discuss your options.

5.5 > Paying income tax on your premium

You will have to pay income tax on the premiums paid by your employer.

5.6 > Cancelling the plan

As the **plan** is part of a group scheme that has been arranged by your employer you are not able to cancel it.

5.7 > Leaving your employer

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

Call us on 0800 028 2915 when you know you're leaving

If you leave the employer that provides this **plan**, it's quick and easy to transfer to a personal plan.

When you transfer to a personal plan with similar cover, we 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 **company agreement** with your company. However we do give all members full access to the complaint resolution process.

Our aim is to make sure you're always happy with the **plan**. 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 **plan** number
- a contact phone number
- the details of your complaint
- any relevant information that we may not have already seen.

Please call us on 0800 454 080.

Or write to:
Health-on-Line
80 Holdenhurst Road,
Bournemouth
BH8 8AQ

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

You may be entitled to refer your complaint to the Financial Ombudsman Service. The ombudsman service can liaise with us directly about your complaint and if we can't fully respond to a complaint within eight weeks or if you are unhappy with our final response, you can ask the Financial Ombudsman Service for an independent review.

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

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

The plan

The cover is provided under an agreement with your **company** who selects the levels of benefits included.

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

Only those people listed in the **company agreement** can be members of this **plan**.

All cover ends when the **lead member** stops working for the **company** or if the **company's** group membership ends.

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

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

Your membership statement is proof of your cover. We may charge you £25 plus VAT if you ask us to provide a copy of your membership statement.

Renewal

At the end of each **plan year**, we will contact the **company** 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 **company** 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 write and tell 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 the plan

If you break any terms of the **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 the **plan**;
- impose different terms to the cover;
- end 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 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 the **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 the **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 company agreement ends

If the **company agreement** 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 **company** 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 the plan

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

Language for the plan

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

6.2 > Our authorisation and regulation details

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.

Our 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)

AXA PPP healthcare is a participant 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 the AXA PPP healthcare website axapphealthcare.co.uk/privacynotice.

Please make sure that everyone covered by this **plan** reads this summary and the full data privacy notice on the AXA PPP healthcare website. If you would like a copy of the full notice call us on 0800 587 0957 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, your employees and **family members** who are covered by the **plan**. This information can be provided by you, those **family members**, your healthcare providers, you as an employer or 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 the **plan** 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;
- manage the **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 the **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 0800 587 0957 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 **plan** 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 or contributed to 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 the **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 the **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 the **plan** may be cancelled in accordance with 'What happens if you break the terms of the **plan**' on page 33.

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 048 1206 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.

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.

chiropractor – a medical practitioner who meets all of the following conditions:
- is fully registered under the Medical Acts
- specialises in chiropractic **treatment**
- is registered under the relevant Act
- is recognised by AXA PPP healthcare as a chiropractor for **out-patient treatment**.

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

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.

cognitive behavioural therapist – a medical practitioner who meets all of the following conditions:
- practices cognitive behavioural therapy
- is recognised by AXA PPP healthcare as a cognitive behavioural therapist.

We will pay for **treatment** by a cognitive behavioural therapist 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 medical practitioners are available on request**

company – the company that pays for the group scheme that the **plan** is part of.

company agreement – our agreement with the **company**. This agreement sets out who can be covered, when cover begins, how it is renewed, and how premiums will be paid.

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.

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

facility – a **private hospital**, or unit listed in the **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) **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 the **plan** after the renewal date following their 30th birthday.

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

» **We will only accept referrals from your NHS GP practice. If you have the Private GP Cover Option we will also accept referrals from a private GP or Doctor@Hand GP.**

hospital list – the list of hospitals, **day-patient units** and **scanning centres** that are available for you to use under the terms of the **plan**.

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

» **The hospital list is on our website at Health-on-Line.co.uk**

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 the membership statement.

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.

osteopath – a medical practitioner who meets all of the following conditions:
- is fully registered under the Medical Acts
- specialises in osteopathy
- is registered under the relevant Act
- is recognised by AXA PPP healthcare as an osteopath for **out-patient treatment**.

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

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 meets all of the following conditions:
- practises physiotherapy
- is recognised by AXA PPP healthcare as a physiotherapist.

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

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

plan – the insurance contract between the **company** and us. The full terms of the plan are set out in the latest versions of:
- the **company agreement**
- any application form we ask you to fill in
- any statement of fact we send you
- this handbook
- the membership statement and our letter of acceptance.

practitioner – a dietician, **nurse**, orthoptist or speech therapist 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

Priority Health specialist – a **specialist**, practitioner, physiotherapist, psychologist, cognitive behavioural therapist, osteopath or chiropractor who meets both of the following conditions:
- is recognised by AXA PPP healthcare
- we have recognised as someone whose fees for covered **treatment** we will pay in full.
- **private hospital** – a hospital listed in the current **hospital list**.

psychologist – a medical practitioner who meets all of the following conditions:
- practices psychology
- is recognised by AXA PPP healthcare as a psychologist.

We will pay for **treatment** by a psychologist 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 psychologists are available on request

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

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 AXA PPP healthcare 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 AXA PPP healthcare a specialist.

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

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 physiotherapy, osteopathy or chiropractic **treatment**
- is fully registered under the relevant Acts
- is recognised by AXA PPP healthcare 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 the **plan** start date or last renewal date. However, during the first year of membership the **plan** may begin part way through a month but will renew from the first of that month the next year.

How to get in touch

Questions about the plan
0800 587 0957
Monday to Friday 8:30am to 5:30pm

Claims
0345 600 7696
Monday to Friday 8am to 6pm

24 hour medical help and information
0800 003 004
Talk to a medical professional at any time, day or night

The plan documents are available in other formats.
If you would like a Braille, large print or audio version, please contact us

PB61597a/04.18

health-on-line