health-on-line

Personal Choice

Membership Handbook April 2017

What you need to know

health-on-line

Contacting us

Your **policy** is underwritten by AXA PPP healthcare Limited, who is also responsible for the settlement of **eligible** claims. All aspects of **policy** administration are undertaken by Health-on-Line on behalf of AXA PPP healthcare Limited.

While it is important that you read and understand this **policy** handbook, we understand that it is often easier to call us to obtain information – so we have a team of Personal Advisers to help you. You should always call them on 0345 600 4461 when you need **treatment** so we can help you to understand the extent of your cover before you incur any **treatment** costs.

Quick reference guide for important information

Policy Administration Team 01202 544475

Available: Monday to Friday 8am to 6pm.

Health-on-Line, 80 Holdenhurst Road, Bournemouth BH8 8AQ

Claims Personal Advisory Team 0345 600 4461

Available: Monday to Friday 8am to 8pm, Saturday 9am to 5pm.

Claims address:

AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL

Health at Hand 0800 003 004

Available: day or night, 365 days a year.

Our health information service. See page 42.

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

We are committed to giving customers access to our products. To contact us by Text Relay 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 Text Relay on 18001 0345 600 4461 and 'Health at Hand' can be contacted on 18001 0800 003 004.

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

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Contents

1. Introduction

What is the purpose of this handbook and how to use it?

This handbook sets out the terms of your cover for Health-on-Line Personal Choice. If you are unsure of which particular Options you have, please refer to your membership statement.

This handbook is an important document as it details:

- the cover you have (both benefits and limitations);
- how to make a claim;
- how your **policy** is administered; and
- other services provided by your **policy**.

Throughout your handbook certain words and phrases appear in **bold type** to indicate they have a special medical or legal meaning. You will find a glossary of these words on pages 56-60, or they will be defined in the section they apply to.

Additionally when we refer to 'you' or 'your' throughout this document, we mean the **policyholder** and any **family members** named on the **policyholder's** membership statement. When you see 'we', 'us' or 'our' we are referring to AXA PPP healthcare.

Most of the information given is relevant to all Options. However, there are instances where information is not relevant to all Options. Where this occurs, we have drawn your attention to which Option we are referring to as follows:

When a sentence or paragraph starts with an Option name and is in this colour orange, it means that the information given relates only to the Option stated.

2. Your cover

Please remember that our policies are not intended to cover all eventualities and are designed to complement rather than replace all the services provided by the National Health Service (NHS).

In return for payment of the premium we agree to provide cover as set out in the terms of this **policy**. Please refer to the definition of **'policy'** in the glossary for details of the documents that make up your **policy**.

Summary of the Health-on-Line Personal Choice Plan

The Personal Choice **policy** offers you cover for necessary **treatment** of new **medical conditions** that arise after you join. It does not cover you for **treatment** of **medical conditions** that existed, or you had symptoms of before joining. However, in some circumstances you may have joined on a different basis, please refer to the 'Existing medical conditions' section for further information. There is also no cover for ongoing, recurrent and long-term conditions (also known as **chronic conditions**). Personal Choice is a modular private medical insurance **policy**, so you may choose the Options that you require. The core benefits are described as 'Core Cover' which includes cover for:

- **in-patient** and **day-patient treatment** and associated **specialists'** charges
- **out-patient surgical procedures**
- **cancer treatment**, including radiotherapy and chemotherapy
- computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) scans.

In addition you may have chosen additional Options and these will be shown on your membership statement. Details of each Option can be found in Section 3.

With this **policy**, you will be entitled to a no claims discount provided you don't make a claim. Please see the 'Additional Information' Section for details of how your no claims discount is calculated.

Be aware:

Your **policy** will not cover you for:	For more information:
Routine pregnancy and childbirth.	Pages 24-25
Charges when **treatment** is received outside of our **Directory of Hospitals**.	Page 39

The key limitations listed below also apply if you have Core cover only. Please refer to your **benefits table** for details of how your benefits may have been extended to cover some of these items.

Your **policy** will not cover you for:	For more information:
Any dental procedures.	Page 18
Out-patient diagnostic tests and **out-patient** consultations.	Page 18
Out-patient therapists', **acupuncturists'**, **homeopaths'** or **practitioners'** charges.	Page 41
Psychiatric **treatment**.	Page 28

Please note:

You can be reassured that the vast majority of **specialists** we recognise are **fee approved specialists** and we routinely pay their **eligible treatment** charges in full.

If you have Option 1 or 2: We also pay **eligible treatment** charges for a **practitioner** up to the level shown within the schedule of procedures and fees.

If you have Option 3: We also pay **eligible treatment** fees in full with a **therapist** and charges for an **acupuncturist** or **homeopath** up to the level shown within the schedule of procedures and fees.

We support our members in identifying a suitable **treatment** provider, however if you choose to receive **treatment** under the direction of a **fee limited specialist** you may have to make a sizeable contribution to your **treatment** costs.

Please see the 'Who we pay for treatment and where you can be treated' section of this handbook for full details.

3. Benefits table and Options

The tables on the following pages show the benefits available to you together with the monetary limits of your **policy**. These benefits are explained fully in this handbook. You must read this table in conjunction with the rest of your handbook.

Please make sure you call us on 0345 600 4461 prior to **treatment** so we can confirm the extent of your cover and any limitations that may apply.

Please note: This **policy** has a compulsory excess of £100 per person per **policy year**. You may also add an optional excess to your **policy** as shown in Option 6.

CORE COVER (applies to all)		
Benefits	**Amount payable**	**Where can I find more information?**
In-patient and day-patient treatment		
1. **Private hospital** and **day-patient unit** charges: including charges for accommodation, **diagnostic tests**, operating theatre charges, nursing care, drugs and dressings, physiotherapy, and surgical appliances used by the **specialist** during surgery.	Paid in full at a **private hospital** or **day-patient unit** listed in the **Directory of Hospitals**.	Pages 39-40
2. Out of directory cash benefit. This benefit is payable if you receive private **in-patient** or **day-patient treatment** at a hospital or **day-patient unit** not listed in the **Directory of Hospitals**.	£50 each day for **day-patient treatment**. £50 each night for **in-patient treatment**.	Page 39
3. **Specialists'** fees (surgeons', anaesthetists' and physicians').	No annual maximum	Pages 38-41
4. **In-patient** consultations – benefit for a consultation with a second **specialist** arranged by the treating **specialist**.	No annual maximum	Pages 38-41
5. Parent hospital accommodation – this benefit is for the cost of one parent staying in hospital with a child under 16 years old while the child is receiving **eligible** private **treatment**. The child must be covered by the **policy** and the benefit is paid from the child's benefits.		

CORE COVER (applies to all)		
Benefits	**Amount payable**	**Where can I find more information?**
In-patient and day-patient treatment continued		
6. Hotel accommodation. This benefit is for the cost of one parent staying in a hotel near the **private hospital** where a child under 16 is receiving **eligible** private **treatment**. The child must be covered by the **policy** and the benefit is paid from the child's benefits.	Up to £100 a night up to £500 a **year**	
Out-patient treatment		
7. **Surgical procedures**.	No annual maximum	Pages 38-41
8. **Active treatment of cancer.** Including charges for radiotherapy (the use of radiation to treat **cancers**) and chemotherapy (the use of drugs to treat **cancers**). If you have Option 9 – This benefit also includes consultations with your **cancer** treating **specialist** (such as an oncologist, surgeon, radiotherapist or haematologist) and **diagnostic tests** that are ordered by your **cancer** treating **specialist**.	No annual maximum	Pages 30-37
9. (i) Computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) on **specialist** referral. (ii) Out of directory scanning cash benefit. This benefit is payable for using a CT, MRI or PET facility not listed as a **scanning centre** in the **Directory of Hospitals**.	Paid in full in a **scanning centre** listed in the **Directory of Hospitals**. £50 each visit	Pages 38-41
Other benefits		
10. Ambulance transport – when you are receiving private **in-patient** or **day-patient treatment** and it is medically necessary to use a road ambulance to transport you between a hospital and another medical **facility**.	Paid in full	
11. **Day-patient** and **out-patient** NHS radiotherapy and chemotherapy cash benefit. This benefit is paid for **day-patient** or **out-patient** radiotherapy or chemotherapy you receive free under the NHS for the **treatment** of **cancer** and only if the **treatment** you receive under the NHS would have been **eligible** for benefit privately under this **policy**.	£50 a day up to £2,000 a **year**	
12. Health at Hand. Confidential medical information.	Immediate access 24 hours a day, 365 days a year	Page 42

CORE EXTRA		
1. **Specialist** consultations.	Up to two **specialist** consultations per person per **year**. **Please note:** Your claim will be based on the date it is paid by us, rather than the date the **treatment** is received. This means that the consultations paid under this benefit may not be the first two consultations carried out.	Pages 38-41
2. **Diagnostic tests** on **specialist** referral.	No annual maximum	Page 18

OPTION 1. STANDARD OUT-PATIENT COVER		
1. **Specialist** consultations.	These three benefits have a combined overall limit of £1,000 a **year**.	Pages 38-41
2. **Diagnostic tests** on **specialist** referral.		
3. **Practitioner** charges.		

OPTION 2. COMPREHENSIVE OUT-PATIENT COVER		
Benefits	**Amount payable**	**Where can I find more information?**
1. **Specialist** consultations.	No annual maximum	Pages 38-41
2. **Diagnostic tests** on **specialist** referral.	No annual maximum	Page 18
3. **Practitioner** charges.	No annual maximum	Pages 38-41

OPTION 3. THERAPIES		
1. **Acupuncturist** and **homeopath treatment** charges.	These two benefits have a combined overall limit of £1,000 a **year**.	Pages 38-41
2. **Therapist treatment** charges.	Within the above limit we will pay for **therapist**, **acupuncturist** and/or **homeopath treatment** in any combination, up to an overall maximum of ten sessions a **year** under referral by your **GP** or our Working Body team.	

OPTION 4. PSYCHIATRIC		
In-patient and day-patient treatment		
1. **Private hospital** and **day-patient unit** charges for psychiatric treatment: including charges for accommodation, **diagnostic tests** and drugs.	Paid in full at a **private hospital** or **day-patient unit** listed in the **Directory of Hospitals**.	Pages 38-41
2. Out of directory cash benefit. This benefit is payable if you receive private **in-patient** or **day-patient treatment** for a psychiatric condition at a hospital or **day-patient unit** not listed in the **Directory of Hospitals**.	£50 each day for **day-patient treatment**. £50 each night for **in-patient treatment**.	Page 39
3. **Specialists'** fees for psychiatric **treatment**.	No annual maximum	Pages 28 and 38-41
4. **In-patient** consultations for psychiatric conditions. Benefit for a consultation with a second **specialist** arranged by the treating **specialist**.	No annual maximum	Pages 28 and 38-41
5. Parent accommodation – this benefit is for the cost of one parent staying in hospital with a child under 16 years old while the child is receiving **eligible** private psychiatric **treatment**. The child must be covered by the **policy** and the benefit is paid from the child's benefits.	Paid in full	
Out-patient treatment		
6. **Specialist** consultations for psychiatric conditions.	No annual maximum	Pages 38-41
7. **Practitioners'** charges for psychiatric **treatment**.	No annual maximum	Pages 38-41

OPTION 5. ANCILLARY BENEFITS		
1. Hospital-at-home – this is for **treatment** provided at home or another clinically appropriate setting for the administration of intravenous chemotherapy for the **treatment** of **cancer** or intravenous antibiotics which otherwise would require you to be admitted for **in-patient** or **day-patient treatment**.	Paid in full when **treatment**: • is provided by a **nurse** under the control of a **fee approved specialist**; and • is provided through a healthcare services supplier which we have a contract with for such services; and • has been agreed by us before the **treatment** begins.	
2. NHS cash benefit. This benefit is paid for each night you receive free **treatment** under the NHS and only if: (i) you are admitted for **in-patient treatment** before midnight (ii) the **treatment** you receive under the NHS would have been **eligible** for benefit privately under this **policy**. There is no requirement for private **treatment** to have preceded any period in an NHS Intensive Therapy Unit or NHS Intensive Care Unit. Please note: the excess on your **policy** will not apply to this benefit.	£100 a night up to £2,000 a **year**	Pages 38-41
3. Oral surgery. This is for **treatment** of the following oral **surgical procedures** following referral by a dentist: • reinsertion of your own teeth following a trauma • surgical removal of impacted teeth, buried teeth and complicated buried roots • enucleation (removal) of cysts of the jaw.	No annual maximum	Page 18
4. Chiropody and podiatry charges.	Up to £150 a **year**	Page 18

OPTION 6. EXCESS

Benefits	Benefit level	Where can I find more information?
Your **policy** has a compulsory excess of £100, which will be applied in addition to any optional excess. For example, if you have chosen a level 1 optional excess with the compulsory excess, your total excess is £200. Optional excess for each person covered by this **policy** each **year**: Level 1 Level 2 Level 3 Excesses do not apply to the following benefits: • **Day-patient** and **out-patient** NHS radiotherapy and chemotherapy cash benefit • NHS cash benefit • Chiropody and podiatry charges • Dental care • Optical cover • Eye test If you make a claim that incurs an excess, and the total cost of the **treatment** falls entirely within your excess, you must still tell us so that we can apply the excess to your **policy** correctly.	 £100 £250 £500	Page 47

OPTION 7. DENTAL AND OPTICAL CASH BENEFIT

1.	Dental care. We will pay 80% of the costs incurred. The maximum amount we will pay in a **year** is as shown:	Up to £300 each **year**	Page 43
2.	Optical cover. We will pay 80% of the costs incurred. The maximum amount we will pay in a **year** is as shown:	Up to £140 each **year** for prescribed spectacles and contact lenses needed to correct vision.	Page 43
3.	Eye test.	Up to £25 each **year** for an eye test.	Page 43

OPTION 8. TRAVEL

See the Health-on-Line Travel Cover Handbook.

OPTION 9. EXTENDED CANCER COVER

Core Cover includes cover for the **in-patient**, **day-patient** and **out-patient treatment** of **cancer** (subject to restrictions on this **policy** for **out-patient treatment** if you do not have Core Extra or Option 1 or 2), including radiotherapy and chemotherapy and where **treatment** is necessary for a prolonged period of time. If you have Option 2 you may have chosen Option 9 and your cover for **cancer treatment** is extended. Please see section 8 for more information.

1.	Additional expenses incurred to support you whilst you are undergoing **active treatment of cancer**. Purchase of wigs Provision of external prostheses	 Up to £150 per **year**. Up to £5,000 per **year**.	Page 30
2.	Hospice donation. This charitable donation is paid for each night you receive end of life care related to **cancer** in a registered hospice or hospice at home.	£100 per night.	Page 30

4. Arranging treatment and making a claim

What do I need to do before receiving treatment?

Simply call us on 0345 600 4461 as soon as your **GP** refers you for private **treatment**. We can then make the necessary checks that the **treatment** is **eligible** before you incur any costs. Where possible, we will assess your claim over the phone, however we may need to ask for more details about your **medical condition** particularly if your **policy** excludes cover for **treatment** of pre-existing conditions.

Sometimes we will need to contact your **GP** or **specialist** for more information before we can authorise a claim.

Alternatively, we may send you a form that you need to take to your **GP** to get completed.

Be aware:

Your **GP** may make a charge for providing information to us and this charge is not covered by the **policy**.

Fast Track Appointments

We have a team who can help you find a **fee approved specialist**. Our service is available to you if your **GP** has given you an 'open referral', meaning they do not specify the **specialist's** name. We can also support you if you would like an alternative to the **specialist** your **GP** has referred you to. In many cases we can also book your appointment with the **specialist** 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.

Working Body – if you experience muscle, bone or joint pain

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.

Step 1

There's no need to see your **GP** first. As soon as you develop a problem, you can call your Personal Advisory team. They'll check you're covered and refer you to the Working Body team who will arrange an initial clinical needs assessment with a physiotherapist. A member of the Working Body team will call you back to arrange your assessment at a time which is suitable for you between 8am – 6pm, Monday to Friday. (We may record and/or monitor calls for quality assurance, training and as a record of our conversation).

Step 2
During the phone call the physiotherapist will listen to your concerns, take you through an initial assessment and then advise the most appropriate **treatment** for you.
Please note: Members under the age of 18 will need to see their **GP** for a referral for these conditions as the Working Body service is not available to them.

How are my medical bills settled?

We normally receive accounts for **treatment** directly from **specialists** or hospitals. We can settle eligible bills direct with the hospital or **specialist**, subject to any excess. If you have paid the accounts, then we will reimburse you.
If you receive any accounts from the hospital or practitioner requesting payment please forward them to us at AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL.
If you need further **treatment** that has not already been authorised, please call us to confirm your cover.

What happens if I require emergency treatment?

Most private hospitals are not set up to receive emergency admissions. In an emergency you should call for an NHS ambulance or visit the accident and emergency department at the local NHS hospital.
However if you have Option 5 and are admitted as an **in-patient** at an NHS hospital, please ask somebody to call us as you may be able to claim for the NHS cash benefit shown on the **benefits table** on page 9.

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 must I provide when making a claim?

4.1 Before we can consider a claim you must ensure that:

- you obtain and complete any form required by us in order to provide us with the necessary information and necessary legal permissions to handle your medical information and to assess your claim. We will require this as soon as possible and no later than six months from the date the **treatment** starts (unless this was not reasonably possible); and
- we receive original invoices for **treatment** costs; and
- you promptly give us all the information we request.

Do I need to provide any other information?

4.2 It may not always be possible to assess the eligibility of your claim from the claim form. In such situations we may require additional information and it is your responsibility to provide any reasonable additional information to enable us to assess your claim.

Be aware:

In order to establish the eligibility of any claim, we may request access to your medical records including medical referral letters. If you unreasonably refuse to agree to such access we will refuse your claim and will recoup any previous monies that we have paid in respect of that **medical condition**.

4.3 There may be instances where we are uncertain about the eligibility of a claim. If this is the case, we may at our own cost ask a **specialist**, chosen by us, to advise us about the medical facts relating to a claim or to examine you in connection with the claim. In choosing a relevant **specialist** we will take into account your personal circumstances. You must co-operate with any **specialist** chosen by us or we will not pay your claim.

What should I do if another party is responsible for some of my claims costs?

4.4 You must contact us if you are able to recover any part of your claims costs from any other party, for example if you have another insurance policy, cover through a state healthcare system or are legally entitled to recover costs from another third party. We will only pay our proper share (see also 13.2(d)). We do this so that we can keep the cost of premiums down. It also means that you can be repaid for any costs you paid yourself, such as your excess or if you paid for private treatment that was not covered by your **policy**.

continued overleaf.

What should I do if the benefits I am claiming for relate to an injury or medical condition caused by another person?

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

This does not change the benefits you can claim under your **policy** (your "Claim") and also means that you can potentially be repaid for any costs you paid yourself, such as your excess or if you paid for private treatment that wasn't covered by your **policy**.

Where appropriate, we will pay our share of the Claim and recover what we pay from the third party.

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

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

In the event you recover our Outlay and interest and do not repay us this recovered amount in full we will be entitled to recover from you what you owe us and your **policy** may be cancelled in accordance with 12.2(e) in the 'Complaint and regulatory information' section.

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 0345 600 4461 and ask for the Third Party Recovery team.

5. Existing medical conditions

Am I covered for treatment of medical conditions that I had prior to joining?

Medical insurance is designed primarily to provide cover for **treatment** of new **medical conditions** that arise after you join. This is the usual position. However, you may have joined on a different basis in which case that fact will be shown on your membership statement. For example, if you have joined from another insurer we may have transferred the medical underwriting terms from your previous policy for **medical conditions** that existed prior to you joining that policy.

If you completed a medical history declaration when you joined, your membership statement will show the **medical conditions** for which we will not cover you for **treatment** and whether we can review that exclusion.

If you did not provide your medical history when you joined, we will cover **treatment** of **medical conditions** that arise after you joined. However, in the first two **years** of cover there is no cover for the **treatment** of pre-existing **medical conditions** or for **treatment** of **specified conditions**. The **policy** terms and table of **specified conditions** are shown on the following pages.

Please note:

The following defined terms apply to this section:

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

pre-existing condition – any disease, illness or injury for which:

- you have received medication, advice or **treatment**; or
- you have experienced symptoms;

whether the condition has been diagnosed or not in the five years before the start of your cover.

specified condition – the **medical conditions** listed in the table below that we will not cover if you have the following **pre-existing conditions**: diabetes, raised blood pressure (hypertension) or undergoing monitoring as a result of Prostate Specific Antigen (PSA) test.

trouble free – when you:

- have not had any medical opinion from a medical practitioner including **GP**'s or **specialists**; or
- have not taken any medication (including over the counter drugs) or followed a special diet; or
- have not had any medical **treatment**; or
- have not visited a **practitioner**, **therapist**, **homeopath**, **acupuncturist**, optician or dentist;

for the **medical condition**.

If you have the following **pre-existing condition** when you joined:	We will not pay for **treatment** of the following **specified conditions** whatever their cause:
have been diagnosed with diabetes	• Diabetes • Ischaemic heart disease • Cataract • Diabetic retinopathy • Diabetic renal disease • Arterial disease • Stroke
have had **treatment** for raised blood pressure (hypertension) in the five years before you joined	• Raised blood pressure (hypertension) • Ischaemic heart disease • Stroke • Hypertensive renal failure
are under investigation, having **treatment** or undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test	• Any disorder of the prostate

Once you have been a member for two consecutive **years**, you may be able to claim for **treatment** of **pre-existing conditions** and **specified conditions** as long as you have had a **trouble free** period of two consecutive years for the **pre-existing condition** since you became a member.

There are some **medical conditions** – those that continue or keep recurring – that you will never be able to claim for. This is because you will never be able to have a consecutive two year **trouble free** period.

What happens when I want to make a claim?

If you completed a medical history declaration when you joined, your membership statement will show any specific exclusions that apply to your **policy**. You should call us to confirm that the **treatment** you need is **eligible**.

If you did not provide your medical history when you joined, we will need to assess your medical history before we can authorise your **treatment**. We may do this by asking for a medical information form or claim form from your **GP** or **specialist**, or by asking for your **GP** notes.

Be aware:

Because we need to assess your medical history, it is possible that we will not be able to authorise your **treatment** straight away. There may be a short delay before we can confirm if your **treatment** is **eligible**.

5.1 We pay for **eligible**:

(a) **Treatment** of a new **medical condition** that arises after you join.

(b) **Treatment** of **pre-existing conditions** and where applicable, their **specified conditions**, once you have been a member for at least two consecutive **years** and have had a consecutive two year **trouble free** period.

5.2 What we do not pay for:

(a) **Treatment** of **pre-existing conditions** and **specified conditions** where that **pre-existing condition** is diabetes, raised blood pressure (hypertension) or you have been undergoing monitoring as a result of Prostate Specific Antigen (PSA) test for the first two **years** after you join.

(b) If you completed a medical history declaration when you joined: **Treatment** of any **medical condition** which you already had when you joined and which you should have told us about when we asked but which you either:

- did not tell us about at all; or
- omitted to tell us about the full extent of it.

This includes:

- any current or previous **medical condition(s)** or symptoms, (whether or not being treated); and
- any previous **medical condition(s)** which recur(s) or which you should reasonably have known about (even if you had not consulted a doctor).

(c) **Treatment** of any other **medical condition** detailed on your membership statement as excluded for benefit.

6. Your cover for certain types of treatment

What is eligible treatment?

Your **policy** covers **eligible treatment**. We consider **treatment** of a **medical condition** to be **eligible** when:

- the **treatment** falls within the benefits of your **policy** and is not excluded from cover by any term in this handbook.
- it is **treatment** of an **acute condition**
- it is **conventional treatment**
- it is not preventive **treatment**
- it does not cost more than an equivalent **treatment** that is as likely to deliver a similar therapeutic or diagnostic outcome
- it is not provided or used primarily for the convenience, financial or other advantage of you, your **specialist** or other health professional.

Will my policy cover me for preventive treatment?

No, this **policy** has been designed to provide cover for necessary and active **treatment** of disease, illness or injury. Therefore, we do not pay for preventive **treatment** or for tests to establish whether a **medical condition** is present when there are no apparent symptoms.

Please note:

We do not pay for genetic tests, when those tests are undertaken to establish whether you have a **medical condition** when you have no symptoms or a genetic risk of developing or passing on a **medical condition**. Please call us before you have any genetic tests as the cost to you may be significant if the tests are not covered by your **policy**.

What other treatments are not covered?

There are also a number of other **treatments** (listed below) that your **policy** does not cover.

These include **treatments** that may be considered a matter of personal choice (such as cosmetic **treatment**), **treatments** which are outside of any Options which you may have and other **treatments** that are excluded from cover to keep premiums at an affordable level (such as **out-patient** drugs and dressings).

6.1 We pay for **eligible:**

(a) **Diagnostic tests** when performed as **in-patient** or **day-patient treatment**.

(b) Core Extra or Options 1 or 2 only: **Out-patient diagnostic tests** ordered by a **specialist**.

(c) Option 5 only: Oral **surgical procedures** listed below following referral by a dentist:
- reinsertion of your own teeth following a trauma
- surgical removal of impacted teeth, buried teeth and complicated buried roots
- enucleation (removal) of cysts of the jaw.

(d) Your first reconstructive surgery after an accident or following surgery for a **medical condition**, provided that:
- we have covered you continuously under a **policy** of **ours** since before the accident or surgery happened
- we agree the cost of the **treatment** in writing before it is done (see also 6.2(o)).

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
- up to 2 sessions of nipple tattooing.

(e) **Treatment** of varicose veins:
- One **surgical procedure** per leg for the lifetime of your membership, for example foam injection (sclerotherapy), ablation or other surgery
- One follow up consultation with your **specialist**
- One simple injection to treat remaining or residual veins when it is carried out within 6 months of the main **surgical procedure**.

(f) Reasonable costs incurred for a live donor to donate an organ or tissue. 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 your Personal Advisory team so we can tell you what support we can offer (see also 6.4(ff)).

(g) Option 5 only: **Treatment** charges made by a qualified chiropodist or podiatrist up to the limit shown in the Option 5 benefits table.

6.2 What we do not pay for:

(a) **Diagnostic tests** other than detailed in 6.1(a) and 6.1(b)

(b) Any separate charge made by a **specialist** for consultations within 10 days after they have performed the **surgical procedure**.

(c) Any dental procedure, including referrals to dental specialists such as periodontists, endodontists, prosthodontists or orthodontists.

(d) **Treatment** which is not medically necessary or which may be considered a matter of personal choice.

(e) **Treatment** of thread veins or superficial veins.

(f) **Treatment** of symptoms generally associated with the natural process of ageing, including **treatment** for the symptoms of puberty and menopause.

(g) **Treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide.

(h) **Treatment** of, or **treatment** which arises from or is in any way connected with alcohol abuse, drug abuse or substance abuse.

(i) Costs associated with the implantation of a mechanical heart pump (Ventricular Assist Device (VAD) or Artificial Hearts) or the device itself.

(j) Any costs incurred as a consequence of **treatment**, medical or surgical intervention or body modification that is not eligible under your **policy**, including increased **treatment** costs.

(k) Any **treatment** of warts of the skin.

(l) Vaccinations, routine preventive examinations or preventive screening.

(m) Preventive **treatment**.

(n) 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**
- there is a genetic risk of you passing on a **medical condition**.

(o) Genetic tests where the outcome of the test is not proven to change the course of **treatment**, for example if the course of **treatment** would be the same regardless of the **medical condition** that has caused your symptoms.

(p) Drugs, dressings or prescriptions that:
- you are given to take home following **in-patient**, **day-patient** or **out-patient treatment**; or
- could be prescribed by a **GP** or bought without a prescription; or.
- are taken or administered when you attend a hospital, consulting room or clinic for **out-patient treatment**.

(q) If you do not have Core Extra or Options 1 or 2: **Out-patient** consultations, **out-patient diagnostic tests** or any other **out-patient treatment** except as detailed in the Core Cover **benefits table**.
(r) The costs of providing or fitting any external prosthesis or appliance.
(s) Charges for general chiropody, podiatry or foot care (including but not limited to gait analysis and the provision of orthotics) even if this is carried out by a surgical podiatrist (other than shown in 6.1(f) if you have Option 5).
(t) Cosmetic (aesthetic) surgery or **treatment**, or any **treatment** relating to previous cosmetic or reconstructive **treatment**, including any cosmetic operation to a reconstructed breast. (See also 6.1(d)).
(u) Costs incurred for, or related to, any kind of bariatric surgery, regardless of the reason the surgery is needed. This includes but is not limited to the fitting of a gastric band or creation of a gastric sleeve.
(v) The removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons (including but not limited to breast reduction).
(w) Any **treatment** of refractive errors.
(x) Any **treatment** to correct long or short-sightedness.
(y) **Treatment** relating to learning disorders, speech delay, educational problems, behavioural problems, physical development or psychological development, including assessment or grading of such problems. This includes, but is not limited to, problems such as dyslexia, dyspraxia, autistic spectrum disorder, attention deficit hyperactivity disorder (ADHD) and speech and language problems including speech therapy needed because of another **medical condition**.
(z) Any charges which you incur for social or domestic reasons (such as travel or home help costs) or for reasons which are not directly connected with **treatment**.
(aa) Any **treatment** costs incurred as a result of engaging in or training for any sport for which you receive a salary or monetary reimbursement, including grants or sponsorship (unless you receive travel costs only).
(bb) Any **treatment** costs incurred as a result of your active involvement in criminal activity.
(cc) Any charges for primary care services, such as any services that would typically be carried out by a **GP** or dentist (except as allowed under the Dental care benefit).
(dd) Any **treatment** needed as a result of nuclear contamination, biological contamination or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed. Please note, for clarity: There is cover for **treatment** required as a result of a **terrorist act** providing that **terrorist act** does not result in nuclear, biological or chemical contamination.

(ee) Claims on this **policy** if you live outside the **United Kingdom** or any **treatment** received outside the **United Kingdom**.

(ff) The cost of collecting donor organs or tissue or for any related administration costs (for example, the cost of a donor search) or for any costs towards organ or tissue donation which is not done in line with appropriate regulatory guidelines.

Will my policy cover me for new or unproven treatments?

Your **policy** only covers you for established medical **treatments**.

Your **policy** covers you for **treatment** and **surgical procedures** that are **conventional treatments**.

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.

You can find our schedule at axappphealthcare.co.uk/fees or call us on 0345 600 4461 and we'll send you a copy.

Your **policy** will also cover **unproven treatment** carried out by a **specialist**, which we define as:

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

If your **specialist** wants to carry out **treatment** that is not **conventional treatment**, it must be authorised by us before it takes place and it must take place in the **UK**. We will need to agree that the **unproven treatment** is a suitable equivalent to **conventional treatment**. If there is no suitable equivalent **conventional treatment**, there is no 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 **fee approved specialist** and hospital in the **Directory of Hospitals**. 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. 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**.

Childbirth, pregnancy and sexual health

Our policies are designed to provide cover for necessary and active **treatment** of a **medical condition** (which we define as a disease, illness or injury). This means for pregnancy and childbirth that we will only pay for **eligible** additional **treatment** made necessary by a **medical condition** that is experienced during that pregnancy and/or childbirth. Your **policy** is not intended to provide cover for preventive **treatment**, monitoring or screening. We do not pay for the normal interventions required during pregnancy or childbirth as they are not **treatments** of a **medical condition**.

Be aware:

As the extent of cover is limited in pregnancy and childbirth we strongly advise you to call our team of Personal Advisers so we can confirm the extent of the cover we will provide before you undertake any **treatment**.

6.3 We pay for **eligible**:

(a) Additional costs incurred for the **treatment** of **medical conditions** when they occur during that pregnancy or childbirth. As an illustration we would consider **treatment** of the following :

- ectopic pregnancy (where the foetus is growing 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 which relate 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**.

6.4 What we do not pay for:

(a) Any costs related to pregnancy or childbirth except the additional costs incurred for **eligible treatment** of a **medical condition**.

(b) Investigations into and **treatment** of infertility, **treatment** designed to increase fertility (including **treatment** to prevent future miscarriage), investigations into miscarriage and assisted reproduction, or any consequence of any of the above or any **treatment** for them.

(c) Contraception or sterilisation (or its reversal) or any consequence of any of them or any **treatment** for them.

(c) **Treatment** of or related to sexual dysfunction, or any consequence of it.

(d) Gender re-assignment operations or any other surgical or medical **treatment** including psychotherapy or similar services which arise from, or are directly or indirectly associated with gender re-assignment.

(e) Any **treatment** for a baby born after either parent has taken any prescription or non-prescription drug or other **treatment** to increase fertility, or as the result of any method of assisted conception such as IVF, while the baby requires **treatment** in a Special Care Baby Unit or requires paediatric intensive care.

7. Recurrent, continuing and long-term treatment

Will my policy cover me for recurrent, continuing or long-term treatment?

Your **policy** covers **treatment** of **medical conditions** that respond quickly to **treatment** – defined in our glossary as **acute conditions**. This **policy is** not intended to cover you against the costs of recurrent, continuing or long-term **treatment** of **chronic conditions**.

We define a **chronic condition** in the glossary on page 57 as:

A disease, illness or injury that has one or more of the following characteristics:

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

Please note:

Your **policy** will cover you for the following phases of **treatment** for a **chronic condition** (subject to the restrictions on this **policy** for **out-patient treatment** if you do not have Core Extra or Options 1 or 2):

- the initial investigations to establish a diagnosis.
- **treatment** for a period of a few months following diagnosis to allow the **specialist** to start **treatment**
- the **in-patient treatment** of acute exacerbations or complications (flare-ups) in order to quickly return the **chronic condition** to its controlled state.

What happens if I require recurrent or long-term treatment?

In the unfortunate event that the **treatment** you are receiving becomes recurrent, continuing or long-term, the costs for **treatment** of that **chronic condition** (including long-term monitoring, consultations, check-ups and examinations) will not be covered under your **policy**. We will advise you if this is the case.

If you have Core Extra, Option 1 or Option 2: However, if you undergo one of the following **surgical procedures** on your heart we will continue to pay for your long-term monitoring, consultations, check-ups and examinations as long as you have an AXA PPP healthcare private medical insurance **policy** with an appropriate benefit, subject to the terms and conditions of that **policy** at the time:

- Coronary artery bypass
- Cardiac valve surgery
- The implantation of a defibrillator or pacemaker
- Coronary angioplasty.

There are certain conditions that are likely to require ongoing **treatment** – such as Crohn's disease (inflammatory bowel disease) – which require management of recurrent episodes where the condition's symptoms deteriorate. Because of the ongoing nature of these conditions we will write to tell you when the benefit for that condition will stop.

Where can I find out more about cover for chronic conditions?

We publish a leaflet which explains how we deal with payment for **treatment** of **chronic conditions**. This is available on the Health-on-Line website: health-on-line.co.uk and can also be obtained from the Policy Administration Team or Claims Personal Advisory Team. You will also find further explanation of how we deal with payment for **cancer treatments** on page 30.

7.1 We pay for **eligible**:

(a) **Treatment** of an **acute condition** and the short-term **in-patient treatment** intended to stabilise and bring under control a **chronic condition**.

(b) Core Extra, Option 1 or Option 2 only: Routine follow-up consultations for the ongoing monitoring after the following surgical **treatments** for heart conditions:
- Coronary artery bypass
- Cardiac valve surgery
- The implantation of a defibrillator or pacemaker
- Coronary angioplasty.

(c) Kidney dialysis for up to six weeks during preparation for kidney transplant.

(d) **In-patient** rehabilitation of up to 28 days when it is part of **treatment**; and
- it is carried out by a **specialist** in rehabilitation
- it is carried out in a recognised rehabilitation hospital or unit which is either listed in the **Directory of Hospitals** or which we have written to confirming it is recognised by us
- it could not be carried out on a **day-patient** or **out-patient** basis or in another appropriate setting
- the costs have been agreed by us before the rehabilitation begins.

We will extend **in-patient** rehabilitation to a maximum of 180 days in cases of severe central nervous system damage caused by an external trauma.

7.2 What we do not pay for:

(a) Ongoing, recurrent or long-term **treatment** of any **chronic condition**.
(b) The monitoring of a **medical condition**.
(c) Any **treatment** which only offers temporary relief of symptoms rather than dealing with the underlying **medical condition**.
(d) Routine follow-up consultations.
(e) Regular or long-term kidney dialysis in the case of chronic kidney failure.

What cover do I have for psychiatric treatment?

Option 4: you have cover for the **treatment** of psychiatric illness, subject to all other benefit limitations and exclusions on your **policy**.

Should you require **in-patient** or **day-patient treatment** of a psychiatric condition, the hospital will contact us prior to your admission to check whether your **policy** will cover that **treatment**. If we are able to confirm cover we will agree with the hospital to pay for an initial period of hospitalisation.

Should you need to stay in hospital longer than was initially agreed, then we will ask the **specialist** to provide further details to enable us to assess why further **treatment** is necessary. Any cover for **treatment** of psychiatric illness will be subject to our rules on **chronic conditions**.

If you do not have Option 4 there is no benefit available for **treatment** of psychiatric illness.

7.3 We pay for **eligible**:

(a) Option 4 only: **In-patient** or **day-patient treatment** of psychiatric illness. We have an agreement with psychiatric hospitals regarding **in-patient treatment** of psychiatric illness under which the hospital will contact us directly to confirm whether cover is available.

(b) Option 4 only: **Out-patient treatment** of psychiatric illness, subject to any **out-patient treatment** limits as shown in the **benefits table**.

7.4 What we do not pay for:

(a) If you do not have Option 4: any **treatment** of psychiatric illness.

(b) **Treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide (see also 6.2(e)).

(c) **Treatment** of, or **treatment** which arises from or is in any way connected with, alcohol abuse, drug abuse or substance abuse (see also 6.2(f)).

8. Your cover for cancer treatment

You are covered for **treatment** of a new **cancer** which arises after you join and for any recurrence of this **cancer**. If you have exclusions because of your past medical history which relate to a **cancer**, then you will not be covered for any recurrence of this **cancer**.

Please refer to section 5 for further information on your cover for pre-existing **medical conditions**.

Your **policy** covers the investigation and **active treatment of cancer**. This includes surgery, radiotherapy or chemotherapy, alone or in combination.

If you have Option 9: **Out-patient specialist** consultations and **diagnostic tests** that are ordered by your **cancer** treating **specialist**. are not subject to the overall **out-patient treatment** limit shown in the **benefits table**.

If you do not have Option 9: The **policy** does not cover the long term management of **cancer** other than shown below and there is no cover for **treatment** given solely to relieve symptoms.

NHS or private?

Whilst you are covered for **eligible cancer treatment** on this **policy** you may decide that you want to receive **treatment** on the NHS. If you are diagnosed with **cancer** you will be referred to one of our specialist nurses in our Healthcare Solutions team. They will be able to give you information on the **treatment** options open to you and support you through your **treatment**.

If you receive your **treatment** as an NHS patient you will be able to claim the NHS cash benefits shown in the **benefits table**, when you receive **eligible day-patient** or **out-patient** radiotherapy or chemotherapy. If you have Option 5 you will also be able to claim the NHS cash benefit shown in the **benefits table** when you receive **eligible in-patient treatment**. If your **treatment** would be **eligible** under your policy as a private patient, but after discussion with our specialist nurses you choose to have NHS **treatment** instead, our specialist nurses will also be able to offer other services, to support you whilst you are receiving NHS **cancer treatment**, for example childcare or domestic help.

If you have Option 9: The **policy** also provides benefit for the purchase of wigs and the provision of external prostheses while you are undergoing **active treatment of cancer**. This benefit is available regardless of whether you are having your **cancer treatment** on the NHS or as a private patient.

AXA PPP healthcare is a member of the Association of British Insurers (ABI). All ABI members who provide **cancer** cover as part of a private medical insurance policy are required to provide details of the cover in the following format to help you understand your cover for **cancer** more clearly.
The following table is a summary of the cover provided for **cancer** under this **policy** for members who do not have Option 9 and should be read alongside the rest of the handbook, including the **benefits table**.

Cancer cover for Health-on-Line Personal Choice for members who do not have Option 9	
Place of treatment	
✔	**Active treatment of cancer** at a **private hospital**, **day-patient unit** or **scanning centre** listed in our **Directory of Hospitals**.
✘	Charges made for the **treatment** of **cancer** at a private hospital, **day-patient unit** or **scanning centre** not listed in the **Directory of Hospitals**.
✔ If you have Option 5	Intravenous chemotherapy received at home in the circumstances shown on the **benefits table**.
✘	**Treatment** received at a hospice.
Diagnostic	
✔	**In-patient** and **day-patient**: • consultations with your **cancer** treating **specialist** (such as an oncologist, surgeon, radiotherapist or haematologist); and • **diagnostic tests**.
✔	**Surgical procedures** as shown below.
✔	CT, MRI and PET scans.
✔ If you have Core Extra or Options 1 or 2	Out-patient consultations with a **specialist** and **out-patient diagnostic tests** ordered by a **specialist**, subject to any **out-patient** benefit limits.

Cancer cover for Health-on-Line Personal Choice for members who do not have Option 9	
	Diagnostic - continued
✘ If you do not have Core Extra or Options 1 or 2	There is no cover for **out-patient** consultations with a **specialist** and **out-patient diagnostic tests**.
✘	Genetic screening required to establish a genetic predisposition to certain forms of **cancer**.
	Surgery
✔	**Surgical procedures** for the **treatment** or diagnosis of **cancer**, as shown on page 21 when that **treatment** has been established as being effective.
✘	Experimental or unproven surgery. Please refer to the 'Your cover for certain types of treatment' section for further information.
	Preventative
✘	Preventative **treatment**, for example: • Screening undertaken as a preventive measure where there are no symptoms of **cancer**. For example, if you receive genetic screening, the result of which shows a genetic predisposition to breast **cancer**, you would not be covered for the screening or a prophylactic mastectomy to prevent the development of breast **cancer** in the future. • Vaccines to prevent the development or recurrence of **cancer**, for example vaccinations for the prevention of cervical **cancer**.
	Drug therapy
✔	Drug **treatment** of **cancer** (such as chemotherapy drugs, hormone therapies and biological therapies) where the drug has been licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and is used within the terms of that licence.
✔	There are some drug **treatments** for **cancer** that are typically given for prolonged periods of time. Such prolonged **treatment** normally falls outside benefit. However in the case of **treatment** of **cancer** we make an exception (subject to the limits detailed below) for chemotherapy drugs and biological therapies such as trastuzumab (Herceptin) and bevacizumab (Avastin). **Please note:** changes in drug licensing mean that **cancer** drug **treatments** covered under this **policy** will change from time to time. For further information on licensed **cancer treatment** please contact our team of Personal Advisers once you know your **treatment** plan.

Cancer cover for Health-on-Line Personal Choice for members who do not have Option 9	
Drug therapy	
✔	These drug **treatments** will be covered for up to: • one year of such **treatment**; or • the period of the drug licence whichever is the shorter. The time limit starts from when you first started receiving the drug **treatment** funded by us. In any event, these drugs will only be **eligible** for benefit when they are used within the terms of their licence and in circumstances where they are proven to be effective **treatments**.
✘	Except for the cover provided for chemotherapy drugs and biological therapies previously described there is no cover for drug **treatment** given to prevent a recurrence of **cancer**, for the maintenance of remission or where its use is continuing without a clear end date. Such ongoing **treatments** are not **eligible** although, if they are given by injection, for example goserelin (Zoladex), we would pay for up to three months to allow the **treatment** to be established.
✘	**Out-patient** drugs and drugs prescribed by your **GP** or that could be bought over the counter. This includes any take home drugs or prescriptions you are given following **in-patient**, **day-patient** or **out-patient treatment**. For example, hormone therapy tablets (such as Tamoxifen) are **out-patient** drugs and therefore are not covered by our policies.
Radiotherapy	
✔	Radiotherapy, including when used to relieve pain.
Palliative	
✘	Except for the radiotherapy for the relief of pain previously described, there is no cover for care needed to relieve symptoms.
End of life care	
✘	There is no cover for end of life care, wherever carried out.
Monitoring	
✔ If you have Core Extra or Options 1 or 2	Follow up consultations and reviews of **cancer** will be covered for 10 years from your last surgery, chemotherapy or radiotherapy for that **cancer**, subject to any **out-patient** benefit limits. Cover will be provided as long as you remain a member of AXA PPP healthcare, subject to the terms and conditions of that **policy** at the time. **Please note:** We will not pay for routine checks that could typically be carried out by your **GP**.

Cancer cover for Health-on-Line Personal Choice for members who do not have Option 9	
Monitoring - continued	
✘ If you do not have Core Extra or Options 1 or 2	Monitoring of **cancer** usually takes place during **out-patient** consultations which are not covered by this **policy**. Therefore you do not have cover for the monitoring of **cancer**.
Limits	
Your **policy** has some time limits for drug **treatments** given for prolonged periods of time, as described in the 'Drug therapy' section of this table and for follow up consultations and reviews as described in the 'Monitoring' section of this table.	
Your **eligible active treatment of cancer** is subject to any monetary limits on this **policy**.	
Other benefits	
✔	Stem cell **treatment** and bone marrow **treatment**, including the reasonable costs incurred for a live donor to donate bone marrow or stem cells as shown on page 22, section 6.3(b).
✘	Any related administration costs (such as, but not limited to, transport costs and the cost of a donor search).

The table below shows the **cancer** cover for members with Option 9.

Cancer cover for Health-on-Line Personal Choice – members with Option 9	
	Place of treatment
✔	**Active treatment of cancer** at a **private hospital**, **day-patient unit** or **scanning centre** listed in our **Directory of Hospitals**.
✔	Intravenous chemotherapy received at home in the circumstances shown on the **benefits table**.
✔	There is a charitable donation payable for each night spent in a hospice or for each night you are receiving hospice at home.
	Diagnostic
✔	Consultations with your **cancer** treating **specialist** (such as an oncologist, surgeon, radiotherapist or haematologist), **diagnostic tests** or procedures ordered by a **specialist**, including CT, MRI and PET scans, and **surgical procedures**.
✔	Cover for genetic testing proven to help the selection of appropriate chemotherapy.
✘	Genetic screening required to establish a genetic predisposition to certain forms of **cancer** will not be covered as this would be considered preventative.
	Surgery
✔	**Surgical procedures** for the **treatment** or diagnosis of **cancer**, as shown in the 'Your cover for certain types of treatment' section when that **treatment** has been established as being effective.
✔	If you would benefit from a new or experimental surgical procedure please contact us. We will discuss your proposed surgical procedure with you and agree the costs in writing before your treatment starts. Please note that we will only pay up to the cost of an equivalent non-experimental **surgical procedure** as listed in the schedule of procedures and fees. **Be aware:** There is no cover for complications that arise as a result of authorised experimental and unproven surgical procedures.
	Preventative
✘	There is no cover for preventative **treatment**, for example: • Screening undertaken as a preventative measure where there are no symptoms of **cancer**. For example, if you receive genetic screening, the result of which shows a genetic predisposition to breast **cancer**, you would not be covered for the screening or a prophylactic mastectomy to prevent the development of breast **cancer** in the future. • Vaccines to prevent the development or recurrence of **cancer**, for example vaccinations for the prevention of cervical **cancer**.

Cancer cover for Health-on-Line Personal Choice – members with Option 9	
	Drug therapy
✔	Drug **treatment** of **cancer** (such as chemotherapy drugs, hormone therapies and biological therapies) where the drug has been licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and is used within the terms of that licence.
✔	There are some drug **treatments** for **cancer** that are typically given for prolonged periods of time. Such prolonged **treatment** normally falls outside benefit. However in the case of **treatment** of **cancer** we make an exception (subject to the limits detailed below) for chemotherapy drugs and biological therapies such as trastuzumab (Herceptin) and bevacizumab (Avastin). These drug **treatments** will be covered when they are used within the terms of their licence, and up to the period of the drug licence. **Please note:** changes in drug licensing mean that **cancer** drug **treatments** covered under this **policy** will change from time to time. For further information on licensed **cancer treatment** please contact our team of Personal Advisers once you know your **treatment** plan.
✔	Unproven drug **treatments** for **cancer** will be covered when you have been invited to be a participant in a randomised clinical trial approved by the appropriate ethics committee. We will pay for your stay in hospital, including your **specialist's** fees while you are receiving the clinical trial drug. The cover and costs must be agreed by us in writing before **treatment** commences.
✔	Cover for chemotherapy and/or biological drug **treatment** given to prevent a recurrence of **cancer** or for maintenance of remission.
✔	Cover for bisphosphonates used to prevent bone damage in **cancer** will be covered when they are administered alongside **eligible** chemotherapy for **cancer**. In addition we will cover the cost of injectable hormone **treatments** used to manage your **cancer** whilst you are undergoing **eligible** chemotherapy for **cancer**. There are also some drug **treatments** given to treat conditions secondary to **cancer**, such as erythropoietin (EPO), which will be covered whilst you are undergoing **eligible** chemotherapy for **cancer**. There is also cover for antivirals, antibiotics, antifungals, anti-sickness and anticoagulant drugs while you are undergoing **eligible** chemotherapy for **cancer**.
✔	**Out-patient** chemotherapy authorised by our clinical team, for example intravenous chemotherapy received at home in the circumstances shown in the **benefits table**.
✘	**Out-patient** drugs and/or drugs prescribed by your **GP** or that could be bought over the counter are not covered by your **policy**. This includes any take home drugs or prescriptions you are given following **in-patient**, **day-patient** or **out-patient treatment**. For example, hormone therapy tablets (such as Tamoxifen) and bisphosphonates that are not administered alongside **eligible** chemotherapy for **cancer** would not be covered by this policy.

Cancer cover for Health-on-Line Personal Choice – members with Option 9	
Radiotherapy	
✔	Radiotherapy, including when used to relieve pain.
Palliative	
✔	**Active treatment of cancer** needed regardless of whether the intention of this treatment is to cure.
✔	Secondary **surgical procedures** needed to relieve symptoms as a direct result of cancer, such as the insertion of a stent or draining of fluid.
End of life care	
✔	We will make a charitable donation if you are being cared for in the end stages of life at a hospice or if you are receiving hospice at home.
Monitoring	
✔	Follow up consultations and reviews of **cancer** will be covered as long as you have an AXA PPP healthcare private medical insurance policy with an appropriate **cancer** benefit. Cover will be subject to the terms and conditions of that policy at the time. **Please note:** We will not pay for routine checks that could typically be carried out by your **GP**.
Limits	
Your policy has some time limits for drug **treatments** given for prolonged periods of time, as described in the 'Drug therapy' section of this table and for the follow up consultations and reviews, as described in the 'Monitoring' section of this table.	
There are no monetary limits that apply to your **eligible active treatment of cancer**.	
Other benefits	
✔	Stem cell **treatment** and bone marrow **treatment**, including the reasonable costs incurred for a live donor to donate bone marrow or stem cells as shown in the 'Your cover for certain types of treatment' section.
✘	There is no cover for related administration costs (such as, but not limited to, transport costs and the cost of a donor search).

9. Who we pay for treatment and where you can be treated

You need to call us before receiving any **treatment**. This will allow us to review our records and check or identify someone to treat you who is **eligible** for benefit, and to confirm to you that the place where **treatment** is being carried out is also covered. Your **GP** may have made an 'open referral' by stating what **treatment** is necessary and the type of **specialist** you require that **treatment** from, but not specifying the **specialist's** name. If this is the case we can support you in identifying a suitable **specialist**, and in many cases we can also book your appointment with the **specialist** for you.

What services under the direction of a fee approved specialist are eligible for benefit?

We pay **eligible treatment charges** made by a **fee approved specialist** for consultations, (including remote consultations by telephone or via a video link. These will be covered under the **out-patient** consultation benefit if we have agreed with the **specialist** that he/she is recognised by us to carry out remote consultations for our members), **diagnostic tests**, **treatment** in hospital and **surgical procedures** when you are referred for **specialist treatment** in that medical speciality by a **GP**, a dentist or a medical professional that we recognise and have approved to make referrals.

You can be reassured that the vast majority of **specialists** we recognise are **fee approved specialists**, so please contact us before receiving any **treatment** and we will help identify a **fee approved specialist** to treat you. 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 **fee approved specialist**.

What services under the direction of a fee limited specialist are eligible for benefit?

If you have **eligible treatment** with a **fee limited specialist** we will only pay up to the amount shown within the schedule of procedures and fees towards their personal charges. This is available on our website: axappphealthcare.co.uk or by contacting our Personal Advisory Team. If you receive **treatment** with a **fee limited specialist** you are likely to need to make a contribution to the fees charged by that **specialist**.

Be aware:

There are some medical providers who we do not recognise at all. If you receive **treatment** from one of these medical providers we will not pay those fees or any other fees for **treatment** costs under the direction of that provider.

What if an anaesthetist becomes involved in my treatment?

Before receiving surgical **treatment** it is advisable to establish which anaesthetist your **specialist** intends to use. This will mean we can tell you if that anaesthetist is a **fee approved specialist**. However, if you don't know when you call us which anaesthetist your **specialist** intends to use we will make every effort to notify you whether they commonly work with an anaesthetist who we do not pay in full. If you choose to receive **treatment** with an anaesthetist who is a **fee limited specialist**, we will pay up to the amount shown within the schedule of procedures and fees towards the charges for their services.

Will hospital charges be paid in full?

When you receive **eligible treatment** under the direction of a **specialist** at a hospital or **day-patient unit** in the **Directory of Hospitals** we will pay the charges from that facility in full. Your **policy** includes cover for computerised tomography (CT), magnetic resonance imaging (MRI) scans and positron emission tomography (PET). If you require CT, MRI or PET under the direction of a **specialist** and use a **scanning centre** listed in the **Directory of Hospitals** we will pay the charges from that facility in full for **eligible treatment**.

If you receive **out-patient treatment** under the direction of a **specialist**, we will pay **eligible treatment** charges in full when they are made directly by a provider we have an agreement with for the use of their facilities on an **out-patient treatment** basis (which may include charges for the use of drugs).

The **Directory of Hospitals** is available on our website: axappphealthcare.co.uk or by contacting our Personal Advisory Team.

Fast Track Appointments

Our Fast Track Appointments team can find up to three suitable **specialists** for you to choose from, and can even book your appointment for you.

Just call us on 0345 600 4461.

What happens if I choose to have treatment at a hospital or scanning centre which is not in the Directory of Hospitals or a facility that you do not recognise?

If you have **in-patient** or **day-patient treatment** in any private hospital which we do not list in the **Directory of Hospitals** or you use a **scanning centre** that is not listed in the **Directory of Hospitals**, then we will pay you only a small cash benefit shown in the **benefits table**. You will be entirely responsible for paying the hospital bills.

If you have Option 5 and receive **eligible in-patient treatment** as an NHS patient incurring no charges at all, then we will pay any NHS cash benefit shown in the Option 5 **benefits table**.

Where can I receive eligible oral surgical and cataract surgical treatment?

We will pay for those oral **surgical procedures** detailed in 6.1(b) when your dentist refers you directly to a **facility** with which we have an agreement to provide a range of oral **surgical procedures**.

If you require a cataract **surgical procedure** we will pay for **eligible treatment** when your **GP** refers you directly to a facility with which we have an agreement to provide cataract **surgical procedures**.

What services provided by a recognised therapist are eligible for benefit?

If you have Option 3: Cover is available for **eligible treatment** with a **therapist** when you are referred by your **GP**, a **specialist** or our Working Body team.

We recognise a large number of **therapists** (physiotherapists, chiropractors and osteopaths) in the UK. We have identified which **therapists** we pay **eligible treatment** fees in full for when you are under the direction of a **specialist**. Please contact us before receiving any **treatment** and we will help identify a **therapist** we recognise or put you in contact with our Working Body team.

If you choose to receive treatment from a **therapist** who we do not recognise then there will be no cover for the cost of their charges.

We will pay up to an overall maximum of up to ten sessions of **treatment** a **year** with a **therapist**, as detailed in the **benefit table**.

If you require more than the overall maximum for your cover level, such **treatment** must be under the direction of a **specialist** or our Working Body team. The **specialist**, or our Working Body team, will then be able to establish whether the **treatment** you are receiving is the most appropriate form of **treatment** for your particular **medical condition**.

What services provided by a recognised practitioner, acupuncturist or homeopath are eligible for benefit?

If you have Option 1 or 2: We will pay for the **eligible treatment** you need with a **practitioner**. We will pay their charges in full when they charge up to the level shown within the schedule of procedures and fees when you are under the direction of a **specialist**
If you have Option 3: We will pay for the **eligible treatment** you need with an **acupuncturist** or **homeopath**. We will pay their charges in full when they charge up to the level shown within the schedule of procedures and fees when you are under the direction of a **specialist** and additionally for **acupuncturist** or **homeopath treatment** under the referral of your **GP**. We will pay up to an overall maximum of up to ten sessions of **treatment** a **year** with an **acupuncturist** or **homeopath** as detailed in the **benefit table**.
The schedule of procedures and fees is available on our website: axappphealthcare.co.uk or by contacting our Personal Advisory team.

9.1 We pay for **eligible**:

(a) Charges made by, or incurred in, a **private hospital** or any NHS hospital for ITU (Intensive Therapy Unit, sometimes called Intensive Care Unit) treatment only when ITU **treatment** immediately follows **eligible** private **treatment** and you or your next of kin have asked for the ITU **treatment** to be received privately.

(b) Option 5 only: NHS cash benefit, as shown in the Option 5 **benefits table**, for each night you receive free **treatment** in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.

9.2 What we do not pay for:

(a) Charges made by a **specialist**, **therapist**, **acupuncturist** or **homeopath** when you have been referred by a member of your family, or if that **specialist**, **therapist**, **acupuncturist** or **homeopath** is a member of your family.

(b) **Treatment** charges made by a **fee approved specialist** or **therapist** who we have identified to you as someone whose fees we will pay in full if, without our prior agreement, they charge significantly more than their usual amount for **treatment**.

(c) Any charges from health hydros, spas, nature cure clinics or any similar place, even if it is registered as a hospital.

(d) Special nursing in hospital unless we have agreed beforehand that it is necessary and appropriate.

(e) Any charges made by, or incurred in an NHS hospital for ITU **treatment**, except as allowed for by 9.1(b).

(f) Any charges made for written reports or any other administrative costs.

10. Health at Hand

24 hour medical support for you and your family

Through our telephone health information service, Health at Hand, you have access to a qualified and experienced team of healthcare professionals, 24 hours a day, 365 days a year.

Whether you are calling because you have late night worries about a child's health, or you have some questions that you forgot to ask your **GP**, it's likely that Health at Hand will be able to provide you with the help you need.

The team of nurses, pharmacists, counsellors and midwives is on hand to give you the benefit of their expertise. They can answer your questions and give you all the latest information on specific illnesses, treatments and medications as well as details of local and national organisations. They can also send you free fact sheets and leaflets on a wide range of medical issues, conditions and treatments, and will happily phone you back afterwards to discuss any further questions you may have from what you have read.

Health at Hand – 0800 003 004

Health at Hand is available to you anytime – day or night, 365 days a year.

You can also email Health at Hand by going to our website: axappphealthcare.co.uk

If calling from outside the UK please dial +44 1737 815 197 – international call rates apply.

Please remember to have your membership number to hand before you call.

Please note:

Health at Hand does not diagnose or prescribe and is not designed to take the place of your **GP**. However, it can provide you with valuable information to help put your mind at rest. As Health at Hand is a confidential service, any information you discuss is not shared with our team of Personal Advisers. If you wish to authorise treatment, enquire about a claim or have a membership query, our team of Personal Advisers will be happy to help you.

11. Option 7 – Dental and Optical Cash Benefit

The following section only applies if you have chosen Option 7:

Dental Treatment

We will pay for **treatment** (including check-up or new dentures) up to the maximum benefit levels shown in the Option 7 **benefits table** on page 10, if you have paid directly to a dentist or dental hygienist, who is registered with the General Dental Council. We will not pay benefit for any premiums you paid under a dental-care contract scheme.

Optical benefit

We will pay benefit up to the maximum benefit levels shown in the Option 7 **benefits table** on page 10, if you have paid an optician for eyesight tests or prescribed spectacles, lenses or contact lenses. This benefit does not cover contact lens check-ups or solutions, non-prescribed spectacle repairs, new frames, replacements needed after accidental damages, or non-prescribed items you buy under an optical care contract scheme.

If you do buy items under an optical-care contract and you want to claim from your **policy**, you must ask your optician to provide a receipt showing the cost of all items you have bought under that contract.

12. Additional information

When can I add other members or change my cover?

You can apply to add a **family member** to your **policy** at any time. Please note that **family members** cannot be added to your **policy** if they are age 75 years or over at the time of joining. Also, you may be able to change your chosen Options at your renewal. Call the Policy Administration Team or your Intermediary to discuss the options open to you and send you any relevant forms to complete. You must keep us fully informed of any changes which take place between sending us any form and receiving our written confirmation that we have made the change.

Can I add my new baby to my policy?

You can apply to add newborn babies (who are born to the **policyholder** or the **policyholder's** partner) to the **policy** from their date of birth. This can normally be done without filling out details of their medical history, provided you add them within three months of their date of birth. However, we will require details of the baby's medical history if the baby has been adopted, or was born after either parent has taken any prescription or non-prescription drug or other **treatment** to increase fertility, or as the result of any method of assisted conception such as IVF. In such circumstances we reserve the right to apply particular restrictions to the cover we will offer and we will notify you of those terms as soon as reasonably possible. This may limit your baby's cover for existing **medical conditions**. This would mean that your baby will not be covered for **treatment** carried out for **medical conditions** which existed prior to joining, such as **treatment** in a Special Care Baby Unit and you will be liable for these costs.

Can I stay on my policy if I go to live abroad?

Please call the Policy Administration Team or your Intermediary as soon as you know you are going abroad.

Can I cancel my policy?

You have a 14 day cooling off period when you join and at each renewal.
Please see section 13.1(g) 'Your rights and responsibilities'.

How can I pay my premium?

At the start of each **policy year** we will calculate your new premium and let you know how much it is. We offer a choice of monthly or annual premiums. Annual premiums can be paid by credit card, Direct Debit or cheque. Alternatively you may pay monthly premiums by Direct Debit.
If you pay by Direct Debit we will collect the first premium when your **policy** starts and subsequent premiums when they fall due.

Be aware:

Important – you must pay your premium when it is due. If you do not we will cancel your **policy** and will not pay for any **treatment** or benefit entitlement arising after the date that the premium became due.

Why do you make changes to my premiums?

We make every effort to maintain premiums at as low a level as possible, without compromising the range and quality of the cover provided. We review premiums each **year** to take account of a range of statistical factors. Typically the cost of premiums has increased at a level higher than the Retail Price Index (RPI). You will receive reasonable notice of any changes in premium. Your premium will also include the amount of any insurance premium tax or other taxes or levies which are payable by law in respect of your **policy**.

I have an excess on my policy – how does this work?

This **policy** has a compulsory excess of £100. You may also have chosen an optional excess which will be applied in addition to your compulsory excess. If you have an excess this is what it means and how it is applied:

- An excess is the amount of money you must contribute towards the cost of any **eligible treatment** each **policy year**. The **eligible treatment** cost is the value of your claim after we have applied any **policy** limits or deductions.
- The excess applies to each person covered by the **policy** in each **policy year**.
- The excess is deducted from any **eligible treatment** costs you incur.
- When a claim is made that involves an excess, we will pay the claim after we have deducted the excess amount.
- The excess is a single deduction that is made regardless of the number of individual **medical conditions** claimed for in that **policy year**.
- Should **treatment** continue beyond your **policy's** renewal date then we will apply the excess:
  1. Once against the costs incurred before this date, and;
  2. Again against the costs incurred on or after the renewal date.
- We will do this irrespective of whether the costs relate to **treatment** for the same **medical condition**.
- We will only apply the excess against medical costs for **treatment** that your **policy** does not cover.

Please note:

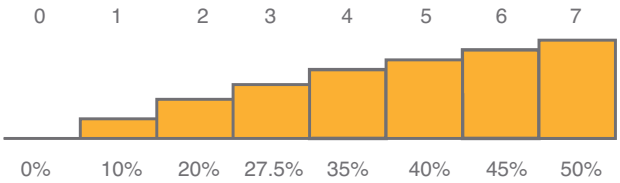
If the first claim relates to a benefit with a monetary limit, then we will reduce the monetary limit by the total cost incurred before we apply the excess. If you have a high excess then you may find that, within a reasonable period, you will reach or exceed the limit of those benefits that have monetary limits.

If you have an excess, here is an example of how the excess operates	
Example 1 –with standard out-patient cover and £100 excess	Standard **out-patient** cover has a benefit limit of £1,000 (for each person each **year**) for **out-patient** consultations, **diagnostic tests** and **practitioners'** charges.
Step One	You develop a medical problem and require £700 of **eligible diagnostic tests** – your first claim for that **policy year**.
Step Two	The £100 excess charge is applied, meaning you pay the first £100 of the claim.
Step Three	We pay the remaining £600 towards the £700 cost of **out-patient treatment**.
Step Four	This £700 total claim reduces your £1,000 benefit limit for **out-patient** consultations, **diagnostic tests** and **practitioners'** charges to £300.
Then...	Later in the same **policy year**, you suffer a different **medical condition**, incurring costs of £450 for **eligible out-patient** consultations and **diagnostic tests** – £150 more than the **policy's** remaining £300 benefit limit.
So...	We pay £300 towards the cost of **treatment**, and you pay the £150 shortfall.

How does the no claims discount scale operate?

This **policy** has a no claims discount (NCD) and your current NCD level is shown on your membership statement, this means that in any NCD year where a person covered on the **policy**:

Does not make a claim	The NCD for that person is increased by one level at the following **policy** renewal date until level 7 is reached.
Does make one or more claims	The NCD for that person is reduced by three levels at the following **policy** renewal date until level 0 is reached.



What is a claim?

- For the purposes of the NCD a claim is any amount of money we pay, no matter how small with the exception of claims under the following benefits:
  - **Day-patient** and **out-patient** NHS radiotherapy and chemotherapy cash benefit
  - NHS cash benefit
  - Chiropody or podiatry charges
  - Dental care
  - Optical cover
  - Eye test
  - Any claim that falls entirely within your excess and you pay the full amount.
- The claim is recorded based on the date it is paid by us, rather than the date the **treatment** is received.
- We will treat separate accounts for the same **medical condition** when they are paid within 180 days of one another as one single claim.

When do you calculate the NCD?

Your NCD level is calculated up to 3 months prior to your **policy** renewal date. This means that a claim paid in the NCD calculation period may not impact on your NCD until the following **year's** renewal.

Should I pay for treatment myself to maintain my NCD level?

Before asking us to pay a small amount of money you should consider the effect this may have on the NCD for the following **year**. It may be appropriate for you to meet the cost of the **treatment** in order to preserve the NCD, for example if it turns out that no further **treatment** is going to be needed. However, your first consideration should always be ensuring that you receive the **treatment** you need.

At renewal, if we have paid claim(s) during the previous NCD year, you may choose to reimburse us the value of the claim(s). If you do this within 30 days of the **policy** renewal date we will recalculate your premium so you continue to benefit from the NCD.

Can I protect my NCD?

We may offer certain people on the **policy** this option for an additional premium. If so, this will be shown on your membership statement at renewal and you must accept this offer within 30 days of the renewal date.

If you accept this offer, it currently operates in this way for each person with NCD protection:

1. In any NCD year where there are no claims paid, their NCD will increase by one level at the **policy** renewal date in line with the table on page 47.
2. When we first pay a claim, their NCD will be retained at the level then in force for the following **policy year**.
3. If, following their first year of claims they then have a claim free year, their NCD will increase at the end of the claim free year by one level in line with the table on page 47.
4. NCD protection will be withdrawn after the second year of claims if claims are paid in any two NCD years of a consecutive three year period.
5. In the event that NCD protection is withdrawn, we would offer renewal at the level of NCD that the person had reached prior to making that claim. The additional premium that was payable in order to protect your NCD will no longer be charged.
6. Please remember that at renewal you have the option of reimbursing us the value of claims from the past NCD year within 30 days of the **policy** renewal date, in order to preserve the NCD as shown on previous page.

13. Complaint and regulatory information

Not happy with our service?

The most important thing for us is to help resolve your concerns as quickly and easily as possible. We'll do all we can to resolve your complaint by the end of the next business day. However, if we can't do this, we'll contact you within five working days to acknowledge your complaint and explain the next steps. Letting us know when you're unhappy with our service gives us the opportunity to put things right for you and improve our service for everybody.

No matter how you decide to communicate your concerns, we'll listen.

You can call us on 01202 544 444, or write to us at:

Health-on-Line,
80 Holdenhurst Road,
Bournemouth
BH8 8AQ

To help us resolve your complaint, we'll need the following:

- Your name and membership details
- A contact telephone number
- A description of your complaint
- Any relevant information relating to your complaint that we may not have already seen.

Financial Ombudsman Service

We will generally issue our final response within eight weeks from when you originally contacted us. However, we will respond sooner than this, if we are able.

If it looks as though our review of your complaint will take longer than this, we will let you know the reasons for the delay and will keep you updated.

If we cannot respond fully to your complaint within eight weeks, or you are unhappy with our final response, you can refer your complaint to the Financial Ombudsman Service for an independent review. The Financial Ombudsman Service will only consider your complaint once we have issued a final response, or if eight weeks has passed since you first notified us of your complaint.

How to contact the Financial Ombudsman Service

The Financial Ombudsman Service,
Exchange Tower,
Harbour Exchange Square,
London,
E14 9SR
By telephone: 0300 123 9 123 or 0800 023 4567
Email: complaint.info@financial-ombudsman.org.uk
Website: financial-ombudsman.org.uk

Please note that the Ombudsman will not normally investigate complaints concerning an insurer's exercise of commercial judgement.
The Ombudsman will also not usually review a complaint where:
• we have not had the opportunity to investigate and consider your complaint
• the final decision issued by us was received more than six months ago
• your case already involves (or has involved) legal action.

What regulatory protection do I have?

AXA PPP healthcare is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority (FCA) and the Prudential Regulation Authority. The FCA have set out rules which regulate the sale and administration of general insurance, which we must follow when we deal with you. Our register number is 202947. This information can be checked from the FCA website: fca.org.uk

The Financial Services Compensation Scheme (FSCS)

We are also participants in the Financial Services Compensation Scheme established under the Financial Services and Markets Act 2000. The scheme is administered by the Financial Services Compensation Scheme Limited (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. The scheme may assist by providing financial assistance to the insurer concerned, by transferring policies to another insurer, or by paying compensation to eligible policyholders.
Further information about the operation of the scheme is available on the FSCS website: fscs.org.uk

What we do with your personal data

Please ensure that you show the following information to others covered under your policy, or make them aware of its contents.

Health-on-Line and AXA PPP healthcare Limited and any intermediaries or reinsurers involved will deal with all personal information supplied to us in the strictest confidence as required by the Data Protection Act 1998. We send personal and sensitive personal information in confidence for processing by other companies and intermediaries, including those located in countries outside the European Economic Area (EEA), including to countries where the laws protecting personal information may not be as strong as in the EEA. We take steps to ensure that any sub-contractors give at least the same protections as we do.

Health-on-Line and AXA PPP healthcare Limited and any intermediaries or reinsurers involved will hold and use information about you and any **family members** covered by your **policy**, supplied by you, those **family members**, medical providers or your employer (if applicable) to provide the services set out under the terms of this **policy**, administer your **policy** and develop customer relationships and services. In certain circumstances we may ask medical service providers (or others) to supply us with further information. When you give us information about **family members** we will take this as confirmation that you have their consent to do so. As the legal holder of the insurance policy we will send most correspondence about the **policy** to the **policyholder**.

We take both data protection and medical confidentiality very seriously and aim, where possible, to correspond with each individual member over the age of 16 about their claim. This may mean a **family member** under the age of 18 may make a claim without the knowledge of the **policyholder**, parent, or carer, for example, where the healthcare provider has determined the member is competent to consent to the medical **treatment**.

If any **family member** over 18 insured under the **policy** does not want us to correspond with the **policyholder** they should apply for their own policy.

We are required by law, in certain circumstances, to disclose information to law enforcement agencies about suspicions of fraudulent claims and other crime. We will disclose information to third parties including other insurers for the purposes of prevention or investigation of crime including reasonable suspicion about fraud or otherwise improper claims. This may involve adding non-medical information to a database that will be accessible by other insurers and law enforcement agencies.

Additionally, we are obliged to notify the General Medical Council or other relevant regulatory body about any issue where we have reason to believe a medical practitioner's fitness to practice may be impaired.

If you have agreed we, and other members of the **AXA UK Group**, may use the information you have provided to us to inform you by letter, telephone, email or mobile message of products and services such as special offers and healthcare information. If you change your mind please contact the Policy Administration Team or write to us at the address on the back of this handbook otherwise we will assume that, for the time being, you are happy to be contacted in this way.

Legal rights and responsibilities

13.1 Your rights and responsibilities

(a) Your **policy** is for one **year**. Prior to the end of any **policy year** we will write to the **policyholder** to advise on what terms the **policy** will continue, provided the **policy** you are on is still available. If we do not hear from the **policyholder** in response we will renew your **policy** on the new terms. Where you have opted to pay premiums by Direct Debit, continuous credit card payments or other payment method, we may continue to collect premiums by such method for the new **policy year**. Please note that if we do not receive your premium, you will not be covered. If the **policy** you were on is no longer available we will do our best to offer you cover on an alternative policy.

(b) You must make sure that whenever you are required to give us any information, all the information you give us is sufficiently true, accurate and complete so as to give us a fair presentation of the risk we are taking on. If we discover later it is not, then we can cancel the **policy** or apply different terms of cover in line with the terms we would have applied had the information been presented to us fairly in the first place.

(c) You and we are free to choose the law that applies to this **policy**. In the absence of an agreement to the contrary, the law of England and Wales will apply.

(d) You must write to Health-on-Line if you change your address; **Health-on-Line, 80 Holdenhurst Road, Bournemouth BH8 8AQ**.

continued overleaf.

(e) Each **family member** may make individual claims under the **policy**, which may be without the knowledge of the **policyholder** in accordance with our approach to personal data. However, only the **policyholder** and we have legal rights under this **policy** and it is not intended that any clause or term of this **policy** should be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999, by any other person including any **family member**. Consequently, the **policyholder** remains liable for excesses and shortfalls incurred by a **family member** under the **policy**.

(f) You must pay your premium when it is due.

(g) The **policyholder** may cancel this **policy** by contacting us during the 14 day cooling off period. The 14 day cooling off period commences on the day that the contract is concluded or the day that full policy terms and conditions are received, whichever is the later. The 14 day cooling off period also applies from each renewal date. If the **policy** is cancelled during the 14 day cooling off period we will return any premium paid for the **policy** providing no claims have been made on the **policy** in relation to the period of cover before cancellation (being no more than 14 days' cover).

If you incur **eligible** claims costs within that period of cover we reserve the right to require the **policyholder** to pay for the services we have actually provided in connection with the **policy** to the extent permitted by law and any return of premium is subject to this. If the **policyholder** does not cancel the **policy** during the cancellation period the **policy** will continue on the terms described in this handbook for the remainder of the **policy year**.

13.2 AXA PPP healthcare's rights and responsibilities

(a) We will tell the **policyholder** in writing the date the **policy** starts and any special terms which apply to it.

(b) We can refuse to add a **family member** to the **policy** and we will tell the **policyholder** if we do.

(c) We will pay for **eligible** costs incurred during a period for which the premium has been paid.

(d) We, or any person or company that we nominate, have subrogated rights of recovery of the **policyholder** or any **family members** in the event of a claim. This means that we will assume the rights of **policyholders** or any **family members** to recover any amount which they are entitled, for example from someone who caused your injury or illness, another insurer or a state healthcare system, and which we have already covered under this **policy**. The **policyholder** must provide

us with all documents, including medical records, and provide any reasonable assistance we may need to enable us to exercise these subrogated rights and must not do anything to prejudice such rights at any time. We reserve the right to deduct from any claims payment otherwise due to you or an amount equivalent to the amount you could recover from a third party or state healthcare system.

(e) If you break any of the terms of the **policy** which we reasonably consider to be fundamental, we may (subject to 14.2(e)) do one or more of the following:
- refuse to make any benefit payment or if we have already paid benefits we can recover from you any loss to us caused by the break;
- refuse to renew your **policy**;
- impose different terms to any cover we are prepared to provide;
- end your **policy** and all cover under it immediately.

(f) If you (or anyone acting on your behalf) make a claim under your **policy** knowing it to be false or fraudulent, we can refuse to make benefit payments for that claim and may declare the **policy** void, as if it never existed. If we have already paid benefit we can recover those sums from you**.** Where we have paid a claim later found to be fraudulent, (whether in whole, or in part), we will be able to recover those sums from you.

(g) We will not do business with any individual or organisation that appears on an economic sanctions list or is subject to similar restrictions from any other law or regulation. This includes sanction lists, laws and regulations of the European Union, United Kingdom, United States of America or under a United Nations resolution. We will immediately end cover and stop paying claims on your **policy** 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 premium payments under a **policy**. In this case, we can cancel your **policy** 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.

(h) We can change all or any part of the **policy** from any renewal date. We will give you reasonable notice of changes to your **policy** terms.

(i) This **policy** is written in English and all other information and communications to you relating to this **policy** will also be in English.

14. Glossary

Throughout this handbook certain words and phrases appear in **bold**. Where these words appear they have a special medical or legal meaning. These meanings are set out below. To aid customer understanding certain words and phrases in this glossary have been approved by the Association of British Insurers and the Plain English Campaign. These particular terms will be commonly used by most medical insurers and are highlighted below by a ◆ symbol.

active treatment of cancer – treatment intended to affect the growth of the **cancer** by shrinking the **cancer**, stabilising it or slowing the spread of disease, and not given solely to relieve symptoms.

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

A full explanation of the criteria we use to decide these matters is available on request.

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

AXA UK Group – AXA PPP healthcare Ltd, Health-on-Line Company (UK), Health and Protection Solutions Ltd, trading as SecureHealth and The Health Insurance Group, AXA Insurance UK PLC, Architas Multi-Manager Limited, AXA ICAS Ltd (trading as Active+), The Permanent Health Company Ltd, AXA Services Limited, Aid-Call Ltd. The companies that we mean by AXA UK Group may change from time to time. Please visit axappphealthcare.co.uk/group for the most up to date list.

benefits table – the table applicable to this **policy** showing the maximum benefits we will pay you.

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

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.

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 centre in which **day-patient treatment** is carried out. The units we recognise for benefit purposes are listed in the **Directory of Hospitals**.

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

Directory of Hospitals – a document we publish on our website: axappphealthcare.co.uk which lists the **private hospitals**, **day-patient units** and **scanning centres** in the **United Kingdom** covered by the **policy**. The facilities listed may change from time to time so you should always check with us before arranging treatment. The Directory of Hospitals lists the hospitals and **day-patient units** in the **United Kingdom** for which we provide cover. We have an agreement with them under which they will provide services to our members. If we are unable, after reasonable negotiation, to conclude the agreement in whole or part, it may be necessary from time to time for us to suspend the use of a hospital, **day-patient unit** or **scanning centre** listed in the Directory of Hospitals to protect the interests of all our members. In such an event we will indicate the suspension on our website.

We also have specific arrangements in regard to **eligible treatment** of cataracts and oral **surgical procedures**.

eligible – those **treatments** and charges which are covered by your **policy**. In order to determine whether a **treatment** or charge is covered all sections of your **policy** should be read together, and are subject to all the terms, benefits and exclusions set out in this **policy**.

facility – a **private hospital** or centre with which we have an agreement to provide a specific range of medical services and which is listed in the **Directory of Hospitals.**
In some circumstances **treatment** may be carried out at an establishment which provides **treatment** under an arrangement with a facility listed in the **Directory of Hospitals**.

family member – (1) the **policyholder's** current spouse or civil partner or any person (whether or not of the same sex) living permanently in a similar relationship with the **policyholder** and (2) any of their or the **policyholder's** children. Children cannot stay on your **policy** after the renewal date following their 25th birthday. The **policyholder's** partner cannot join the **policy** if they are age 75 years or above at the date of joining.

fee approved specialist – a **specialist** who we have identified as someone whose fees for **eligible treatment** we routinely pay in full.

fee limited specialist – a **specialist** who we have identified as someone to whom we will only pay up to the amount shown within the schedule of procedures and fees towards their **eligible treatment** charges. The schedule of procedures and fees is available on our website: axappphealthcare.co.uk or by contacting our Personal Advisory Team.

GP – a general practitioner on the General Medical Council (GMC) GP register. We will only accept referrals from your NHS GP practice.

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

A full explanation of the criteria we use to decide these matters is available on request.

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

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

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

out-patient ◆ – a patient who attends a hospital, consulting room, or out-patient clinic and is not admitted as a **day-patient** or an **in-patient**.

policy – the insurance contract between you and us. Its full terms are set out in the current versions of the following documents as sent to you from time to time:
- any application form we ask you to fill in
- any Statements of Fact we have sent you
- these terms and the **benefits table** setting out your cover
- your membership statement and our letter of acceptance.

policyholder – the first person named on the **policy** membership statement. If the first insured person on the **policy** membership statement is under 18 then we will treat the parent/guardian named on the application form as the policyholder. In this circumstance the policyholder will not be entitled to cover under this **policy**. We will not accept policyholders over the age of 75 at date of joining.

practitioner – a practising member of certain professions allied to medicine who, in all cases, meets our recognition criteria for benefit purposes in their field of practice and who we have told in writing that we currently recognise them as a clinical practitioner for benefit purposes. However, we will only pay **out-patient treatment** benefits for such services when a **specialist** refers you to them (except where the **benefits table** allows otherwise). When such persons provide such services to you as part of your **in-patient** or **day-patient treatment** those services will form part of the **private hospital** charges.
The professions concerned are dieticians, **nurses**, orthoptists, psychologists, psychotherapists and speech therapists.
A full explanation of the criteria we use to determine these matters is available on request.

private hospital – a hospital listed in the current **Directory of Hospitals**.

scanning centre – a centre in which **out-patient** CT (computerised tomography), MRI (magnetic resonance imaging) and PET (positron emission tomography) is performed. The centres we recognise for benefit purposes are listed in the **Directory of Hospitals**.

specialist – a medical practitioner with particular training in an area of medicine (such as consultant surgeons, consultant anaesthetists and consultant physicians) with full registration under the Medical Acts, who meets our criteria for specialist recognition for benefit purposes, and whom we have told in writing that we currently recognise them as a specialist for benefit purposes in their field of practice.

Out-patient treatment only:
a **medical practitioner** with full registration under the Medical Acts, who specialises in musculoskeletal medicine or sports medicine, or a practitioner in podiatric surgery who is registered under the relevant Act; and who, in all cases, meets our criteria for limited **specialist** recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise them as a **specialist** for benefit purposes in that field for the provision of **out-patient treatment** only.
A full explanation of the criteria we use to recognise a specialist is available on request.

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

terrorist act – any clandestine use 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 with full registration under the Medical Acts, who is a practitioner in physiotherapy, osteopathy or chiropractic who is registered under the relevant Act; and who, in all cases, meets our criteria for therapist recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise them as a therapist for benefit purposes in that field for the provision of **out-patient treatment** only.

A full explanation of the criteria we use to decide these matters is 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 – twelve calendar months from when your **policy** began or was last renewed.

health-on-line

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