

Private Medical Insurance

Corporate Healthcover*4*life

Handbook

April 2019

Your Handbook

This Handbook sets out the terms of the cover for the Company HealthCover4life range of plans.

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

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

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

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

If you are unsure of which particular plan your company has chosen or your cover level, please refer to your Certificate of Cover.

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 page 52, 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 **lead member** and any **family members** named on the **lead member's** Certificate of Cover. When you see 'we', 'us' or 'our' we are referring to the Permanent Health Company (PHC) on behalf of AXA PPP healthcare, who is the insurance company who underwrite this product.

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1. Your cover

Please remember that our plans 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).

The plans are underwritten by AXA PPP healthcare Limited and administered by PHC, a member of the global AXA Group. The plans are valid for 12 months and are renewable annually. In return for payment of the premium we agree to provide cover as set out in the terms of the plan. Please refer to the definition of '**plan**' in the glossary for details of the documents that make up the **plan**.

HealthCover4life policies offer 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**).

Summary of the HealthCover4life Plans

Plan 1 provides comprehensive cover for eligible **in-patient** and **out-patient treatment**. This includes benefits for psychiatric **treatment**, radiotherapy and chemotherapy and full cover for **out-patient** physiotherapy. Additional benefits include cover for parent accommodation, private ambulance trips, full cover for **physiotherapist, therapist, acupuncturist** and **homeopath treatment** and newborn cash benefit. There are additional options available on Plan 1 - option a excludes psychiatric cover and Plan 1 Plus and 1a Plus provide additional benefits.

Plan 2 also provides comprehensive cover for the core **in-patient** and **out-patient** benefits. The additional benefits also include parent accommodation, private ambulance trips and £1500 per **plan year** for psychiatric **treatment, physiotherapist, therapist, acupuncturist** and **homeopath treatment**. There are additional options available on Plan 2 - option a excludes psychiatric cover and Plan 2 Plus and 2a Plus provide additional benefits.

Plan 3 provides full cover for core **in-patient** benefits, **out-patient** CT, MRI and PET scans and radiotherapy and chemotherapy. Cover is included for psychiatric **treatment** and **out-patient treatment** is covered up to £1,000 per **plan year**. Additional benefits include parent accommodation, private ambulance trips and NHS cash benefits.

There are an additional two options available on Plan 3. Option a excludes psychiatric cover. Option b is a six week wait plan (excluding psychiatric cover) which means that if the required **in-patient, day-patient** or **out-patient** surgical **treatment** is not available on the NHS within six weeks, then prompt access to **treatment** is available under the plan. Excesses are not available on Plan 3b.

Plan 4 provides cover for **eligible in-patient** and **day-patient treatment**. **Out-patient treatment** is limited to two **specialist** consultations per **year** and £500 for **physiotherapist, therapist, acupuncturist** and **homeopath treatment**. Psychiatric and additional benefits are not covered.

The **plan** also includes Expert Help which provides telephone access to healthcare experts and our Counselling and Support Service.

The above is only an overview of the benefits, please see your **benefits table** for full details.

Be aware:

The plan will not cover you for:	For further details:
Charges when treatment is received outside of our Directory of Hospitals .	Page 19
General dental procedures	Page 35
Routine pregnancy and childbirth	Page 41

These are just some of the key limitations that relate to the **plan**, please read this Handbook for full details.

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. We also pay **eligible treatment** fees in full with a **therapist** or **physiotherapist** and charges for an **acupuncturist, homeopath** or **practitioner** up to the level shown within the schedule of procedures and fees.

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.

2. Company HealthCover4/life benefits table

Your Certificate of Cover specifies which of the below plans applies to you.

If your Certificate of Cover shows Plan 1, 2 or 3 followed by an a or a b, your company has chosen for you to have either option a or b applied to the plan. Please see page 9 for details of options a and b.

The table on the following few pages shows the benefits available to you together with the monetary limits of the **plan**. These benefits are explained fully in this Handbook. You must read the table in conjunction with the rest of your Handbook.

The **Directory of Hospitals** lists the hospitals and **day-patient units** in the **United Kingdom** for which we provide cover. Please see the 'Who we pay for **treatment** and where you can be treated' section of this Handbook for full details.

Key to **benefits table**:

✓ = benefit is covered ✗ =benefit is not covered ppy = per person, per **plan year**

Benefits	Plan 1	Plan 2	Plan 3	Plan 4
In-Patient and Day Care				
Nursing and accommodation Operating theatre/recovery room Prescribed medicines and drugs Diagnostic procedures Consultations Specialist physicians' fees Physiotherapy	✓	✓	✓	✓
Fees for the above benefits are paid in full within a private hospital or day-patient unit listed in the Directory of Hospitals .				
Out of directory cash benefit	£50 each day for in-patient or day-patient treatment	£50 each day for in-patient or day-patient treatment	£50 each day for in-patient or day-patient treatment	£50 each day for in-patient or day-patient treatment
The out of directory cash benefit is payable if you receive eligible private in-patient or day-patient treatment at a hospital or day-patient unit not listed in the Directory of Hospitals .				
Surgeons' and anaesthetists' fees	✓	✓	✓	✓
We will pay eligible fees in full under the above benefit when a surgeon or anaesthetist charges up to the level within our published schedule of procedures and fees. Please see the 'Who we pay for treatment' section of this Handbook for full details.				
Psychiatric services	Up to 45 days ppy	Up to 28 days ppy	Up to 28 days ppy	✗
Please see the 'Your cover for certain types of treatment' section for more details				

Benefits	Plan 1	Plan 2	Plan 3	Plan 4
Parent accompanying child	✓	✓	✓	✓
The above benefit is paid in full for the cost of one parent staying in hospital with a child under 16 years old while the child is receiving eligible private treatment , and paid up to £100 a night up to £500 a year for a parent staying in a hotel close to the hospital. The child must be covered by the plan and the benefit is paid from the child's benefits				
Out-patient Section 1				
CT, MRI and PET scans on specialist referral	✓	✓	✓	✓
If you require a CT, MRI or PET we will make full payment, or set the charges against any excess you may have, if you use a scanning centre listed in the Directory of Hospitals . Pre-notification is required for second and subsequent scans.				
Active treatment of cancer	✓	✓	✓	✗
This includes charges for radiotherapy (the use of radiation to treat cancers) and chemotherapy (the use of drugs to treat cancer). For Plan 1, 2 and 3 this benefit also includes consultations with your cancer treating specialist (such as oncologist, surgeon, radiotherapist or haematologist) and diagnostic tests that are ordered or performed by your cancer treating specialist . Plan 4 members have access to NHS cancer support (see page 31).				
Out-patient surgical procedures	✓	✓	✓	✓
Out-patient Section 2				
Consultations, including with practitioners	✓	✓	✓	Two consultations ppy
Diagnostic procedures	✓	✓	✓	✓
The next three benefits in section 2 have a combined overall limit of up to:	No annual maximum	£1,500 ppy	£1,000 ppy	£500 ppy
Psychiatric services including consultations	✓	✓	✓	✗
Physiotherapy	✓ We will pay up to an overall maximum of 20 sessions a year for physiotherapy under referral by your GP or our Working Body team	✓ Within the above limit we will pay up to an overall maximum of 10 sessions a year for physiotherapy under referral by your GP or our Working Body team	✓ Within the above limit we will pay up to an overall maximum of 10 sessions a year for physiotherapy under referral by your GP or our Working Body team	✓ Within the above limit we will pay up to an overall maximum of 10 sessions a year for physiotherapy under referral by your GP or our Working Body team

Benefits	Plan 1	Plan 2	Plan 3	Plan 4
Therapist, acupuncturist and homeopath treatment	✓ We will pay therapist, acupuncturist and/or homeopath treatment in any combination up to an overall maximum of 20 sessions a year under referral by your GP or, for therapist treatment , our Working Body team	✓ Within the above limit we will pay therapist, acupuncturist and/or homeopath treatment in any combination up to an overall maximum of 10 sessions a year under referral by your GP or, for therapist treatment , our Working Body team	✓ Within the above limit we will pay therapist, acupuncturist and/or homeopath treatment in any combination up to an overall maximum of 10 sessions a year under referral by your GP or, for therapist treatment , our Working Body team	✓ Within the above limit we will pay therapist, acupuncturist and/or homeopath treatment in any combination up to an overall maximum of 10 sessions a year under referral by your GP or, for therapist treatment , our Working Body team
Additional benefits				
Home nursing	✓	✓	✓	✗
Under the Home nursing benefit we will pay the fees of a qualified nurse to provide nursing at home under the direction of the treating specialist/consultant for medical reasons. This must follow immediately after in-patient or day-patient treatment . We will not pay for nursing at home for domestic reasons.				
Private ambulance	✓	up to £250 ppy	up to £250 ppy	✗
The private ambulance benefit is payable 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 .				
External prosthesis	Up to £5,000 for the lifetime of your membership	Up to £5,000 for the lifetime of your membership	Up to £5,000 for the lifetime of your membership	Up to £5,000 for the lifetime of your membership
This benefit is paid towards the cost of providing an external prosthesis .				
NHS cash benefit	£200 a night up to a maximum of £6,000 ppy	£100 a night up to a maximum of £2,000 ppy	£100 a night up to a maximum of £2,000 ppy	£100 a night up to a maximum of £2,000 ppy
This benefit is paid for each night you receive free treatment under the NHS and only if: <ul style="list-style-type: none"> • you are admitted for in-patient treatment before midnight • the treatment you receive under the NHS would have been eligible for benefit privately under this plan. There is no requirement for private treatment to have preceded any period in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.				
NHS day care cash benefit	£150 per claim	£50 per claim	£50 per claim	£50 per claim
This benefit is paid when you receive free day-patient treatment under the NHS and only if: <ul style="list-style-type: none"> • the treatment you receive under the NHS would have been eligible for benefit privately under this plan. 				
Hospital at home	✓	✓	✓	✓
The Hospital at home benefit is for treatment provided at home or another clinically appropriate setting for the				

Benefits	Plan 1	Plan 2	Plan 3	Plan 4
<p>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. We will pay in full when treatment:</p> <ul style="list-style-type: none"> • is provided by a nurse under the control of a 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. 				
Radiotherapy and chemotherapy cash benefit	✓ £50 a day up to £2,000 ppy	✓ £50 a day up to £2,000 ppy	✓ £50 a day up to £2,000 ppy	✗
<p>This benefit is paid for day-patient or out-patient radiotherapy or chemotherapy you receive free for the treatment of cancer and only if the treatment you receive would have been eligible for benefit privately under this plan.</p>				
Hospice cash benefit	✓ £75 a day	✓ £75 a day	✓ £75 a day	✗
<p>This benefit is only payable at the terminal stage of cancer and is payable to the claimant up to a maximum of 15 days per plan. Per plan means that benefit is only payable once during the term of the whole plan and not on a per plan year basis.</p>				
Hospice donation	✓ £75 a day	✓ £75 a day	✓ £75 a day	✗
<p>This benefit is a charitable donation to a hospice and is only available at the terminal stage of cancer. This benefit is payable to a maximum of 15 days per plan. Per plan means that benefit is only payable once during the term of the whole plan and not on a per plan year basis.</p>				
Provision of external prostheses	✓ Up to £5,000 per year	✓ Up to £5,000 per year	✓ Up to £5,000 per year	✗
Purchase of wigs	Up to £150 per year	Up to £150 per year	Up to £150 per year	
<p>This benefit is for additional expenses incurred to support you during your active treatment of cancer.</p>				
Newborn cash benefit	£200 per birth	£100 per birth	£100 per birth	✗
<p>This benefit is payable for each birth occurring after one of the parents named on the birth certificate has been a member for at least 10 consecutive months.</p>				
Recuperative care	Up to £500 ppy	✗	✗	✗
<p>This is to cover the services of i) a nurse for secondary nursing care; or ii) a care assistant for the following personal care services: Household duties: washing, cleaning, cooking, shopping, general household chores, preparing meals. Help with personal hygiene: washing and bathing, eating and drinking, dressing and undressing, using the toilet. Benefit is payable when the care follows within 90 days after your date of discharge for eligible in-patient treatment that the plan covers, is certified by your GP or specialist as being necessary because of your medical or domestic circumstances, and if the claim is for those domestic duties that would normally be carried out by the person claiming the benefit.</p>				
Expert Help	✓	✓	✓	✓

Benefits	Plan 1	Plan 2	Plan 3	Plan 4
Counselling and Support Service	✓	✓	✓	✓
See page 42 for further details on Expert Help and the Counselling and Support Service.				
Options				
Option a				
Removal of all psychiatric benefit	✓	✓	✓	✗
Option b				
Six week wait and removal of psychiatric benefit	✗	✗	✓	✗
<p>Plan 3b six week wait plans will cover the costs of in-patient or day-patient treatment, or any surgical procedure, if the NHS could not provide treatment within six weeks after the date on which the treatment should be undertaken. The only exceptions to this provision are shown in the following paragraph (immediate cover) and if you have day-patient or out-patient radiotherapy or chemotherapy.</p> <p>Immediate cover: We will pay as per the stated in-patient and day care benefits (not including in-patient psychiatric treatment) in the above benefits table for the surgical procedures shown below whether or not the patient could obtain treatment as an NHS patient within six weeks after the date on which treatment should be undertaken:</p> <ul style="list-style-type: none"> • varicose veins surgery • tonsillectomy • correction of squint • insertion of grommets • haemorrhoidectomy • adenoidectomy • cataract surgery • removal of bunions (hallux valgus) • removal of gall bladder (laparoscopic cholecystectomy) <p>There is no benefit available for urgent or emergency treatment or if the NHS could provide in-patient or day-patient treatment or a surgical procedure within six weeks after the date on which treatment should be undertaken.</p>				

Optional upgrade

If your company has chosen Plan 1, 1a, 2 or 2a, the **plan** may also include the 'Plus' upgrade module. This will be shown on your Certificate of Cover.

Benefits	Plan 1 Plus	Plan 2 Plus
In-Patient and Day Care		
Nursing and accommodation Operating theatre/recovery room Prescribed medicines and drugs Diagnostic procedures Consultations Specialist physicians' fees Physiotherapy	✓	✓
Fees for the above benefits are paid in full within a private hospital or day-patient unit listed in the Directory of Hospitals and paid up to the normal daily rates published and charged for a private hospital or day-patient unit not listed in the Directory of Hospitals .		
Surgeons' and anaesthetists' fees	✓	✓
We pay eligible treatment charges in full when they are made by a specialist or anaesthetist who is recognised. Please see the 'Who we pay for treatment' section of this handbook for full details.		
Out-patient		
Routine out-patient management of certain specified chronic conditions	✓	✓
We will pay for out-patient routine follow-up consultations and associated diagnostic tests with a specialist for the purpose of monitoring the on-going control of a specified chronic condition .		
Fees for visits for a private GP for consultations and GP minor surgery	Up to £500 ppy	Up to £500 ppy
Doctor@Hand consultations	Up to five consultations a year with a Doctor@Hand GP	Up to five consultations a year with a Doctor@Hand GP
Access to a GP service for online, video or telephone consultations. For more information about how to register and use this service, please visit axapphealthcare.co.uk/DAH . If your group has chosen to include an excess, it will not be taken off this benefit.		

3. Understanding your certificate of cover

Please take a moment to look at your Certificate of Cover and check that all your (and your dependants') details are correct. Please call our Member Services team on 01923 770 000 if any amendments need to be made.

Your Certificate of Cover provides you with the following important information:

Which plan do I have?

Please look at the section marked plan on your Certificate of Cover and this will detail which **plan** your **group** has chosen eg Plan 1, 1a, 2, 2a, 3, 3a, 3b or 4.

Which hospital can I use?

The section of your Certificate of Cover marked plan will detail whether or not the London Upgrade option is included on the **plan**. Please see the section 'Where you are covered for treatment' in this Handbook for details of which hospitals are included in the London Upgrade Option.

Do I have any exclusions on my plan?

This depends on the underwriting terms applicable to your **plan**, please read the section 'Existing medical conditions' in this Handbook for further details.

One of the following codes will be shown below your certificate number:

MORI = moratorium

FMU = full medical underwriting

CPME = continued personal medical exclusions

MHD = medical history disregarded

VAR = various. This means that you and your dependants have different underwriting terms applied to them. These will be shown on page 2 of your Certificate of Cover enclosed with your membership documents.

All plans are subject to the general exclusions detailed in this Handbook.

Do I have to pay an excess?

The section marked plan on your Certificate of Cover will detail whether or not there is an excess to pay on the **plan** and how much this will be.

Excesses are applicable to each person on the **plan** who claims, each **plan year**. This means that a new excess will become payable where **treatment** continues into a new **plan year**.

When does the plan year start?

The start date of the **plan** is shown on your Certificate of Cover and each subsequent renewal notice.

Where a particular benefit has an annual limit payable, this amount is available in full each **plan year** for valid claims.

4. Excesses

Is there an excess on the plan?

If your plan includes an excess this will be shown on your Certificate of Cover. The excess is for each person covered by the **plan** each **year**.

Excesses do not apply to the following benefits:

- Newborn cash benefit
- NHS cash benefit
- **External prosthesis**
- Provision of external prostheses and purchase of wigs in relation to **treatment of cancer**
- Hospice donation/cash benefit.
- NHS day care cash benefit
- Doctor@Hand consultations

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 **plan** correctly.

I have an excess – how does this work?

If you have an excess on the **plan**, 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 **plan year**.
- The excess applies to each person covered by the **plan** in each **plan 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 **plan year**.
- Should **treatment** continue beyond the **plan'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**.

5. Your how to claim guide

Claims line 0800 068 7111

Are you unwell?

The first thing you should do is see your General Practitioner (**GP**).

Simply call us 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 **plan** 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 **plan**.

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.

Do you need to see a specialist, physiotherapist, practitioner, therapist, acupuncturist or homeopath?

Before seeing the **specialist, physiotherapist, practitioner, therapist, acupuncturist** or **homeopath** you must call the claims line on 0800 068 7111.

All **treatment** must be pre-authorised through the helpline as we do not want you to incur any charges that may not be covered. We will pay **eligible** fees in full from a **fee-approved specialist, physiotherapist, or therapist**. We will pay **eligible** fees in full when an **acupuncturist, homeopath** or **practitioner** charges 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**.

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

The **Directory of Hospitals** lists the hospitals and **day-patient units** in the **United Kingdom** for which we provide cover. Please see the 'Who we pay for **treatment** and where you can be treated' section of this Handbook for full details.

What will we check when you phone?

Although the exact requirements will depend on your individual circumstances, our Claims Team are likely to discuss the following with you:

- If you would like us to support you in identifying a suitable **specialist**, you can ask your **GP** for an 'open referral'. This means your **GP** makes a general referral by stating what **treatment** is necessary and the type of specialist you require that **treatment** from, but they do not specify the specialist's name. If your **GP** has referred you to a specific person for **treatment** we will check they are recognised by us for benefit.
- 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.
- If you need hospital **treatment** we will discuss with you the cover available and which hospitals, **day-patient units** and **scanning centres** are covered by the **plan**. Also if you are having a **surgical procedure** it would be helpful for us to know the procedure code so we can identify the exact **treatment** you will be having.

Please note:

Plan 3b six week members:

1. There is no cover for urgent or emergency **treatment**.
2. If a **surgical procedure** or **in-patient** or **day-patient treatment** is necessary, you will need to establish that **treatment** is not available within six weeks on the NHS after the date on which the **treatment** should be undertaken (unless the **surgical procedure** is one specified in the list in your **benefits table**, or you are receiving **day-patient** or **out-patient** radiotherapy or chemotherapy).

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

Step 1

There's no need to see your **GP** first. As soon as you develop a problem, you can call the claims line on 0800 068 7111. They'll check you're covered and refer you to the Working Body team at AXA PPP healthcare 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 – Friday (calls may be recorded and/or monitored for quality assurance, training and as a record of your 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.

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

Step 1

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

Step 2

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

Step 3

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

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

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

Please note: There is no cover for the treatment of psychiatric illness on Plan 1a, Plan 2a, Plan 3a, Plan 3b or Plan 4. You are however still entitled to receive counselling services through our Counselling and Support Services (more information on page 42)

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

For skin concerns you can use our self-referral service

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

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

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

If the service isn't suitable for you, or you decide you'd rather not use it, it's best to make

an appointment with your GP as soon as possible for further advice.

Over 18's only. Children under 18 will need a GP referral.

Completed claims forms

Please send your completed claim form and any invoices to:

PHC Claims, 32 Church Street, Rickmansworth, Hertfordshire, WD3 1DJ

Settling accounts

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 the rates we have agreed with the hospital or centre, minus any excess.

Should any accounts be sent direct to you please forward them immediately to us at PHC Claims Ltd, 32 Church Street, Rickmansworth, Hertfordshire, WD3 1DJ. Some hospitals may require you to pay for some services eg x-rays, blood tests etc yourself. If this does happen please forward the receipted original invoices as above.

If you need further **treatment** that has not already been authorised, please call us to confirm your cover.

If at any time you require assistance please call the claims line on:

0800 068 7111

What happens if you 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 are admitted as an **in-patient** at an NHS hospital, please ask somebody to telephone us as you may be able to claim for the NHS cash benefit shown in the core **benefits table**.

Plan 3b six week wait members: These **plans** will only provide benefit for **in-patient** or **day-patient treatment** and **surgical procedures** if the NHS cannot provide **treatment** within six weeks after the date on which **treatment** should be undertaken.

Be aware:

This means that conditions for which urgent or emergency **treatment** is needed are not covered by the **plan**. As you will appreciate, if you have a serious or life threatening condition which needs urgent **treatment** the NHS will treat that condition within six weeks. The **plan** therefore will not cover it because of its urgent or emergency nature.

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 you 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 you 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 (or patient's declaration and consent form) alone. 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 you do if you have cover on another insurance policy?

4.4 You must tell us if you can claim any of the cost from another insurance policy. If another insurance policy is involved we will only pay our proper share.

What should you do if another party is responsible for some of your claims costs?

4.5 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 13.2c)). 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 the **plan**.

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

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

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

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

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

In the event you recover our Outlay and interest and do not repay us this recovered amount in full we will be entitled to recover from you what you owe us and your membership to the **plan** may be cancelled in accordance with 13.2d) 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 0800 068 7111 and ask for the Third Party Recovery team.

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

Your plan can provide benefit for **eligible treatment** provided by **specialists, physiotherapists, therapists, practitioners, acupuncturists and homeopaths**.

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.

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 by contacting the claims line on 0800 068 7111 or visiting thephc.co.uk/phc-members-area/how-to-claim. 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**.

If you have the 'Plus' Option: We will pay in full if you receive treatment from a **fee limited specialist**, as long as the fee is not significantly higher than the amount they usually charge for **treatment**, or a similar **treatment**.

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 private 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. The **plan** 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.

Be aware:

If you do not have the London Upgrade option included on the **plan, treatment** including **in-patient, day-patient, out-patient** and **diagnostic tests** at the following hospitals and all **out-patient** centres associated with these hospitals is excluded:

- BUPA Cromwell Hospital
- London Bridge Hospital
- The Lister Hospital
- King Edward VII's Hospital Sister Agnes
- Princess Grace Hospital (including 30 Devonshire Street)
- Wellington Hospital
- Portland Hospital
- The London Clinic
- Harley Street Clinic (including the Harley Street Clinic's facilities at any other location throughout the **UK**).

Please see your **Directory of Hospitals** for further details, including details of **out-patient** and diagnostic centres associated with the above hospitals.

If your **group** has selected to include the London Upgrade option on the **plan** then we will pay for **treatment** at the above hospitals.

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 **eligible** private **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 **eligible in-patient treatment** as an NHS patient incurring no charges at all, then we will pay any NHS cash benefit shown in the core **benefits table**. This includes treatment in an NHS Intensive Therapy or Intensive Care Unit or **treatment** received in a private facility paid for by the NHS.

If your group has chosen Plan 1 Plus, 1a Plus, 2 Plus or 2a Plus: You have extended cover for **treatment** received at any hospital, **day-patient unit** or **scanning centre** in the **United Kingdom** and we will pay their charges up to the normal daily rates published and charged by the hospital, **day-patient unit** or **scanning centre**.

Please note: if you do not have the London Upgrade included on the **plan** the extended cover does not apply to **treatment** at the London hospitals listed above. These hospitals will still be excluded from your cover.

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

We will pay for those oral **surgical procedures** detailed in 10.1b) when your dentist refers you directly to a **facility** with which we have an agreement to provide a range of oral **surgical procedures**.

If your GP or optician says you require a cataract **surgical procedure** we will pay for **eligible treatment** at a **facility** with which we have an agreement to provide cataract **surgical procedures**. You need to contact us to find an appropriate **facility** for your **treatment**.

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

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

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

If you choose to receive **treatment** from a **therapist** or **physiotherapist** 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 10 sessions of **treatment** a **year** (20

sessions of **treatment a year** on plan 1) **with a therapist or physiotherapist**, as detailed in the **benefits table**.

If you require more than 10 sessions of **treatment** in a **year** (20 sessions of **treatment** in a **year** on Plan 1), 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?

- We will pay for the **eligible treatment** you need with an **acupuncturist, homeopath or 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** and additionally for **acupuncturist or homeopath treatment** under the referral of your **GP**. The schedule of procedures and fees is available by contacting the claims line on 0800 068 7111 or at www.thephc.co.uk/phc-members-area/how-to-claim

We will pay up to an overall maximum of up to 10 sessions of **treatment a year** (20 session of treatment a year with Plan 1) with an **acupuncturist or homeopath**, as detailed in the **benefits table**. If you require more than 10 sessions of **treatment a year** (20 session of **treatment a year** on Plan1), such **treatment** must be under the direction of a **specialist**. The **specialist** will then be able to establish whether the **treatment** you are receiving is the most appropriate form of **treatment** for your particular **medical condition**.

6.2 We pay for *eligible*:

- Treatment** charges in full made by a **fee approved specialist, physiotherapist or therapist**.
- Treatment** charges made by a **practitioner, acupuncturist or homeopath** up to the level set out in the schedule of procedures and fees or at the amount charged if lower.
- 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.
- NHS cash benefit, as shown on the **benefits table**, for each night you receive free **treatment** in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.

6.3 What we do not pay for:

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

- b) **Treatment** charges made by a **fee approved specialist, therapist** or **physiotherapist** 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 under 6.2c) above.
- f) Any charges made for written reports or any other administrative costs.

7. Existing medical conditions

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

This depends on the underwriting terms applicable to the type of cover your **group** has chosen. Your Certificate of Cover will state which of the following underwriting terms (moratorium, full medical underwriting, continued personal medical exclusions or medical history disregarded) has been applied to the **plan**:

Moratorium

We will provide cover for **treatment of medical conditions** that arise after you join. 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 **plan** terms and table of specified conditions are shown below.

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 page that are associated with 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 **GPs** 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 any medical professional including, but not limited to, **practitioners, physiotherapists, osteopaths, dentists or opticians**; for the **medical condition**.

If you have the following pre-existing condition when you joined:	We will not pay for the treatment of the following specified conditions whatever their cause:
have been diagnosed with diabetes	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Raised blood pressure (hypertension) • Ischaemic heart disease • Stroke • Hypertensive renal failure
have been investigated, monitored or treated as a result of a Prostate Specific Antigen (PSA) test in the five years before you joined	<ul style="list-style-type: none"> • 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 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**.

7.1 *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.

7.2 *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) **Treatment** of any other **medical condition** detailed on your Certificate of Cover as excluded for benefit.

Full medical underwriting

If when you joined the plan you completed a full medical history declaration then you will have made a declaration as to your medical history and we will have decided whether any exclusions for any **medical conditions** should be applied to the **plan**. Your Certificate of Cover will show the **medical conditions** for which we will not cover you for **treatment**.

Continued personal medical exclusions (CPME)

If you transferred the plan to PHC on a continued personal medical exclusions (CPME) basis from an existing private medical insurance plan with another insurer we will have transferred the existing personal exclusions imposed by the previous insurer to your PHC Certificate of Cover. In the case of a previous insurer's moratorium, we will have transferred the balance of the un-expired moratorium period as applicable to the previous insurer.

Please note that when you transfer from one private medical insurer to another, with no break in cover, then you are transferring to a different policy with different benefits, terms and conditions. It is only the medical exclusions that were applied by your previous insurer that will be continued under the new **plan**, not the previous plan benefits, terms and conditions.

Medical history disregarded (MHD)

If you joined the plan on an MHD basis this means we will not have applied any exclusions for specific **medical conditions** to the **plan**.

The general exclusions of the HealthCover4*life* apply to all plans irrespective of the underwriting basis selected.

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**.

8. Your cover for cancer treatment

The following table is a summary of the cover provided for **cancer** under this **plan** and should be read alongside the rest of the Handbook, including the **benefits table**. This table follows the format required by the Association of British Insurers (ABI) to help you understand your cover for **cancer** more clearly.

Cancer cover for Company healthcover4life Plans 1, 2, and 3 (for Cancer cover for Plan 4 see page 30)	
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 in 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 or performed by your cancer treating 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.
✓	<p>If you would benefit from a new or unproven surgical procedure please contact us. We will discuss your proposed surgical procedure with you and agree the level of benefit we will pay in writing before your treatment starts.</p> <p>Please note: That we will only pay up to the equivalent non-experimental surgical procedure as listed in the schedule of procedures and fees.</p> <p>Be aware:</p> <p>There is no cover for complications that arise as a result of authorised experimental and unproven surgical procedures.</p>

Preventative	
x	<p>There is no cover for preventative treatment, for example:</p> <ul style="list-style-type: none"> • 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.
Drug therapy	
✓	<p>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.</p>
✓	<p>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.</p> <p>Please note: Changes in drug licensing mean that cancer drug treatments covered under this plan will change from time to time. For further information on licensed cancer treatment please contact our claims team once you know your treatment plan.</p>
✓	<p>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 specialists fees while you are receiving the clinical trial drug. The cover and costs must be agreed by us in writing before treatment commences.</p>
✓	<p>Cover for chemotherapy and/or biological drug treatment given to prevent a recurrence of cancer or for maintenance of remission.</p>
✓	<p>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.</p> <p>There are some other 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.</p> <p>There is also cover for antivirals, antibiotics, antifungals, anti-sickness and anticoagulant drugs while you are undergoing eligible chemotherapy for cancer.</p>

✓	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 the plan . 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 plan .
Radiotherapy	
✓	Radiotherapy, including when used to relieve pain.
✓	Proton beam therapy (PBT) for: <ul style="list-style-type: none"> - central nervous system (brain and spinal cord) cancer or malignant solid cancers in members aged 21 and under - chordomas or chondrosarcomas (types of spine cancer) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised) - cancer of the iris, ciliary body or choroid parts of the eye (uveal melanoma) which has not spread (metastasised)
✗	Accelerated charged particle therapies, except as described above.
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 a PHC 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	
There are no time limits on your eligible active treatment of cancer . The plan provides cover throughout your active treatment and for any follow up consultations and reviews while you are a member of PHC.	
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 cover for the provision of external prostheses up to the benefit limit shown in the benefits table .
✓	There is cover for the provision of wigs up to the benefit limit shown in the benefits table .
✗	There is no cover for related administration costs (such as, but not limited to, transport costs and the cost of a donor search).
✗	There is no cover for the harvesting and storing of sperm or eggs.

NHS cancer support - for Plan 4 members

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

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

We will pay if:

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

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

9. Recurrent, continuing and long-term treatment

Will the plan cover me for recurrent, continuing or long-term treatment?

The **plan** covers **treatment** of **medical conditions** that respond quickly to **treatment** – defined in our glossary as **acute conditions**. This **plan** 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 52 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:

The **plan** will cover you for the following phases of **treatment** for a **chronic condition**:

- 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 the **plan**. We will advise you if this is the case.

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, scans and examinations for the **surgical procedure**.

We will continue to pay for these as long as you have a PHC private medical insurance **plan** with an appropriate benefit, subject to the terms and conditions of that **plan** at the time:

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

Please note:

We will not pay for routine checks that could typically be carried out by your **GP**, such as anticoagulation, lipid monitoring or blood pressure monitoring.

Cover for specified chronic conditions

If you have Plan 1 Plus, 1a Plus, 2 Plus or 2a Plus: This plan also covers you for **out-patient** routine follow up consultations and associated **diagnostic tests** (but not **out-patient** drugs and dressings) with a **specialist** for the purpose of monitoring the on-going control of a specified **chronic condition** up to the levels allowed in the **benefits table**.

We define what we mean by a specified **chronic condition** in the glossary on page 52 as: angina, asthma, diabetes, epilepsy, heart valve problems, high blood pressure, glaucoma, osteoarthritis, rheumatoid arthritis, thyroid problems and ulcerative colitis.

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**. You will also find further explanation of how we deal with payment for **cancer treatments** under the section 'Your Cover for Cancer treatment' in this Handbook.

9.1 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) Long term monitoring, consultations, check-ups, scans and examinations for the following **surgical procedures** for heart conditions:
 - Coronary artery bypass
 - Cardiac valve surgery
 - The implantation of a defibrillator or pacemaker
 - Coronary angioplasty
- c) **Plan 1 Plus, 1a Plus, 2 Plus and 2a Plus: Out-patient** routine follow-up consultations (and associated **out-patient diagnostic tests**) with a **specialist** for the purposes of monitoring the on-going control of a specified **chronic condition**.
- d) **In-patient** rehabilitation of up to 28 days when it is part of **treatment** of an **acute condition**; and
 - it follows an acute brain injury, such as a stroke; and
 - it is carried out by a **specialist** in rehabilitation; and
 - 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; and
 - it could not be carried out on a **day-patient** or **out-patient** basis or in another appropriate setting; and

- the costs have been agreed by us before the rehabilitation begins.

9.2 *What we do not pay for:*

- Ongoing, recurrent or long-term **treatment** of any **chronic condition**.
- The monitoring of a **medical condition** except as allowed in 9.1b).
- Any **treatment** which only offers temporary relief of symptoms rather than dealing with the underlying **medical condition**.
- Routine follow-up consultations, except as allowed in 9.1b) above.
- Regular or long-term kidney dialysis in the case of chronic kidney failure.

What cover do I have for psychiatric treatment?

If the **plan** includes psychiatric benefit you have cover for the **treatment** of psychiatric illness, subject to all other benefit limitations and exclusions on your **plan**.

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 **plan** 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**.

Please note:

There is no cover for the **treatment** of psychiatric illness on Plan 1a, Plan 2a, Plan 3a, Plan 3b or Plan 4.

9.3 *We pay for eligible:*

- In-patient** and **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.
- Out-patient treatment** of psychiatric illness (except for those plans detailed above) subject to any **out-patient treatment** limits as shown in the **benefits table**.

9.4 *What we do not pay for:*

- Treatment** which is directly or indirectly related to a deliberately self-inflicted injury or an attempt at suicide (see also 10.2f)).
- Treatment** of, or **treatment** which is in any way connected with, alcohol abuse, drug abuse or substance abuse (see also 10.2f)).

10. Your cover for certain types of treatment

What is eligible treatment?

The **plan** covers **eligible treatment**. We consider **treatment** of a **medical condition** to be **eligible** when:

- the **treatment** falls within the benefits of the **plan** 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 the plan cover me for preventive treatment?

No, this **plan** 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**. We will pay for genetic testing when it is proven to help choose the best course of drug **treatment** for your **medical condition**. This means that it must be recommended in the drug licence for a specific targeted therapy, such as HER2 testing for the use of Herceptin for breast **cancer**.

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

What other treatments are not covered?

There are also a number of other **treatments** (listed below) that the **plan** does not cover. These include **treatments** that may be considered a matter of personal choice (such as cosmetic **treatment**) and other **treatments** that are excluded from cover to keep premiums at an affordable level (such as **out-patient** drugs and dressings).

10.1 We pay for **eligible**:

- a) **Diagnostic tests** ordered or performed by a **specialist**.
- b) 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.
- c) Your first reconstructive surgery after an accident or following surgery for a **medical condition**, provided that:
 - you have been continuously covered under a private medical insurance policy since before the accident or surgery happened
 - we agree the cost of the **treatment** in writing before it is done (see also 10.2q)).

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.
- d) Up to £5,000 for the lifetime of your membership towards the cost of an **external prosthesis** needed after an accident or following surgery for a **medical condition**, provided that:
 - you have been continuously covered under a private medical insurance policy since before the accident or surgery happened; and
 - the claim for the **external prosthesis** is made within 12 months of the amputation or removal of the body part.
 - 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) Plans 1, 2 and 3 for the **treatment of cancer**: Reasonable costs incurred for a live donor to donate either bone marrow or stem cells. If you plan to donate either bone marrow or stem cells, or receive bone marrow or stem cells from a live donor, please call us so that we can tell you what support we offer.

10.2 What we do not pay for:

- a) **Diagnostic tests** ordered by anyone other than a **specialist**.

- b) Any dental procedures, including referrals to dental **specialists** such as periodontists, endodontists, prosthodontists or orthodontists.
- c) **Treatment** which is not medically necessary or which may be considered a matter of personal choice.
- d) **Treatment** of symptoms generally associated with the natural process of ageing, including **treatment** for the symptoms of puberty and menopause.
- e) **Treatment** of thread veins or superficial veins.
- f) **Treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide.
- g) **Treatment** of, or **treatment** which arises from or is in any way connected with, alcohol abuse, drug abuse or substance abuse.
- h) Costs associated with the implantation of a mechanical heart pump (Ventricular Assist Device (VAD) or Artificial Hearts) or the device itself.
- i) Any costs incurred as a consequence of **treatment**, medical or surgical intervention or body modification that is not **eligible** under the **plan**, including increased **treatment** costs.
- j) Any **treatment** of warts of the skin.
- k) Vaccinations, routine medical examinations, preventive screening/examinations, investigative tests, including monitoring of a condition irrespective of:
 - a) whether **treatment** for the condition has taken place under the plan,
 - b) your previous medical history,
 - c) your family medical history.
- l) Preventive **treatment**.
- m) 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**.
- n) 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.
- o) 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**.
- p) The costs of providing or fitting any external prosthesis or appliance, except as shown in 10.1d) or in relation to **cancer** as shown in the **benefits table**.
- q) The costs for any replacement teeth or hair, including hair transplants.
- r) 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 10.1c)).
- s) 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).
- t) Any **treatment** of refractive errors.
- u) Any **treatment** to correct long or short-sightedness.
- v) **Treatment**, relating to learning disorders, 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**.
- w) 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**.
- x) 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).
- y) 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.
- z) Claims on this **plan** if you live outside the **United Kingdom**.
- aa) Plan 3 six week wait plans: Anything outside the terms of cover, which for clarity includes any urgent or emergency **treatment**. We also do not pay for **treatment** of any **medical condition** unless **treatment** is not available under the NHS within six weeks after the date on which required **treatment** should be undertaken. This requirement shall not apply to those **surgical procedures** listed in the core **benefits table** or you are receiving **day-patient** or **out-patient** radiotherapy or chemotherapy.
- bb) Any **treatment** received outside the **United Kingdom**.

cc) Transplants:

- any **treatment** related to either donor or recipient for any procedure involving transplantation or implantation operations or **treatment** directly or indirectly related to such operations (except as shown in 10.1f)).
- except as shown in 10.1f): any **treatment** related to donor or autologous transplants of bone marrow.
- except as shown in 10.1f): any **treatment** related to stem cell procedures.
- the cost of collecting donor organs or tissue or for any related administration costs.

dd) Weight reduction or **treatment** of obesity, or any care involving weight reduction as the main method of **treatment**, including medical, surgical or psychiatric care.

ee) Any **treatment** costs incurred as a result of your active involvement in criminal activity.

ff) Charges for general chiropody 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.

gg) Any charges for primary care services, such as any services that would typically be carried out by a **GP** or dentist.

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

Will the plan cover me for new or unproven treatments?

The **plan** 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 safe and effective for the **treatment** of your **medical condition** through substantive peer reviewed clinical trials 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 axapphealthcare.co.uk/fees or thephc.co.uk/phc-members-area/how-to-claim or call us on 0800 068 7111 and we'll send you a copy.

The **plan** 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 towards the hospital, **specialist**, anaesthetist and/or other provider. All unproven treatment must be agreed by us in writing, so you are clear how much we will pay towards your treatment.

We recommend you check with the hospital, **specialist**, anaesthetist and/or other

provider how much they will charge for your **treatment** so you know how much will be your responsibility to pay..

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

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

Childbirth, pregnancy and sexual health

Our plans 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. The **plan** 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 contact the claims team so we can confirm the extent of the cover we will provide before you undertake any **treatment**.

10.3 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**.

Be aware:

Plan 3b six week wait members:

- Many **medical conditions** arising during pregnancy and childbirth would

require urgent or emergency **treatment**. As the NHS would provide this **treatment** within six weeks, it is unlikely that there will be any cover on the **plan** for such **treatment**.

10.4 *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.
- d) **Treatment** of or related to sexual dysfunction, or any consequence of it.
- e) 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.
- f) 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.

11. Supporting you and your family

Expert Help

Have you ever wished a friend or someone in your family was a medical expert? You'd be able to talk to them whenever you liked and they'd have time to listen, reassure and explain in words you understand. Being there to help with your health questions is just what our Expert Help services are here for. Our medical teams, including nurses and a wide variety of healthcare professionals can answer the questions you might often wish you could ask.

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

Call with your health queries any time

Our medical team are ready to help whether you want to talk about a specific health worry, medication and treatment, or simply need a little guidance and reassurance. You can speak to them whenever you want to – day or night.

Health at Hand 0800 027 1393

24 hours a day, 365 days a year

The experts

- Nurses
- Midwives*
- Counsellors
- Pharmacists*

Health at Hand is provided by AXA PPP healthcare.

*Health at Hand midwife and pharmacists services available 8am to 8pm Monday to Friday, 8am to 4pm Saturdays and 8am to 12pm on Sundays.

Health information you can trust

Our online Health Centres bring together the latest information from our own experts, specialist organisations and NHS resources. You can also put your own questions to our panel of experts at our regular live online discussions. Alternatively you can email us your question through the Ask the Expert online panel and the appropriate medical professional will respond.

Visit www.axapphealthcare.co.uk/health-information

The experts

Extensive panel including but not limited to doctors, psychologists, physiotherapists and dieticians.

Support from our Dedicated Nurse Service

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

Our claims line will put you in touch with a dedicated nurse on diagnosis. 24 hours a day 365 days a year.

The experts

- Dedicated nurses

Counselling and Support Service

Sometimes daily life can seem full of challenges.

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

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

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

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

Summary of the service:

Personal Support

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

Face-to-face counselling

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

Counselling via email

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

LifeManagement™ support

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

Online portal

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

It is a completely confidential and impartial service and you can call it as often as you need to, 24 hours a day, 7 days a week.

To speak to someone please call 0800 316 1212. To access the online portal go to:

Visit: www.axabesupported.co.uk

Username: phc

Password: supported

12. Additional information

When can I add other members?

If you want to join or add **family members** to the **plan** we will send you the forms to complete fully with the information we request. Depending on your agreement with your **group**, there may be restrictions on when you can add **family members** to the **plan**.

Please ask your **group** administrator for details.

Can I add my new baby to the plan?

You can apply to add newborn babies (who are born to the **lead member** or the **lead member's** partner) to the **plan** 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 the plan if I go to live abroad?

You will not be able to keep your current membership if you go to live abroad.

Can I cancel the plan?

As your membership is part of a **group** membership that has been arranged by the **group**, you do not have the right to cancel it.

Will I have to pay income tax on the premiums?

If cover is available under an arrangement with your employer, membership to the **plan** will give rise to a liability for income tax on the premiums paid by your employer, less any amount made good by you as the employee.

Leaving the plan and want to continue your cover?

If you are leaving your employment or your membership to the legal entity is ending you should notify your group administrator and/or PHC as you will no longer be eligible for cover. There is the option to continue your private medical insurance by transferring to a personal plan with our underwriter AXA PPP healthcare.

For the vast majority of existing PHC members, AXA PPP healthcare can cover you for existing **medical conditions** with no additional medical underwriting, when transferring to a plan with comparable benefits and restrictions.

We recommend that you contact your **group** administrator to confirm if any special continuation arrangements are in place or contact AXA PPP healthcare as soon as you know you will be leaving your **group** plan on 0800 533 5962.

Please note that in order to transfer without any further medical underwriting you must usually have a quotation from the relevant insurer within 30 days of leaving your **group** plan.

We or AXA PPP healthcare may try to get in touch with you as soon as we know you are leaving your employment to let you know more about your options. Should you wish to review your options with AXA PPP healthcare you won't need to fill in any forms or have any kind of medical examination, everything can be arranged on the phone.

13. Complaint and regulatory information

What should I do if I have reason to complain?

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

If you are dissatisfied with the service we have provided or if you feel that we have made a wrong decision, we will of course try to address your concerns – your feedback is vital to helping us improve.

If you think things have gone wrong for you and you are unhappy with us, please contact: PHC in the first instance and we will try to resolve your complaint.

32 Church Street, Rickmansworth, Hertfordshire, WD3 1DJ

Tel: 01923 770 000

We will acknowledge your complaint upon receipt. To allow us to investigate your complaint fully, the Financial Conduct Authority (FCA) gives us up to eight weeks to get back to you. However, we will respond sooner than this if we are able.

The Financial Ombudsman Service

The Financial Ombudsman Service will review your complaint if you remain dissatisfied after our final response has been issued, the address you need to write to is:

The Financial Ombudsman Service

Exchange Tower, Harbour Exchange Square, London E14 9SR

Telephone: 0800 023 4567 or 0300 123 9 123

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

Website: www.financial-ombudsman.org.uk

The Ombudsman will review complaints about:

- the way in which your **plan** was sold to you;
- the administration of your **plan**; and
- the handling of any claims.

Please note that the Ombudsman will not normally investigate complaints concerning an insurer's exercise of commercial judgement.

The Ombudsman will also not generally review a complaint where:

- you have not received a final decision;
- the final decision issued by a company was received more than six months ago; or
- your complaint already involves (or has involved) legal action.

What regulatory protection do I have?

The Financial Conduct Authority (FCA)

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

The FCA was established by government to provide a single statutory regulator for financial services. The FCA is committed to securing the appropriate degree of protection for consumers and promoting public understanding of the financial system.

The FCA have set out rules which regulate the sale and administration of general insurance which we must follow when we deal with you. The PHC's FCA register number is 310293, AXA PPP healthcare's register number is 202947.

This information can be checked by visiting the FCA register which is on their website:

www.fca.gov.uk/register or by contacting the FCA on 0800 111 6768 or 0300 500 8082.

We provide information only on our own products. If you would like further details on any of our products please contact us.

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 is governed by FCA Rules and 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:

www.fscs.org.uk

Your personal information

Here is a summary of the data privacy notice that you can find on our websites: axapphealthcare.co.uk/privacynotice and thephc.co.uk/privacy-notice

Please make sure that everyone covered by this **plan** reads this summary and the full data privacy notice on our websites. If you would like a copy of the full notice call us on 0800 454 4080 and we'll send you one.

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

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

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

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

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

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

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

If you want to ask to exercise any of your rights just call us on 0800 454 4080 or write to us.

Legal rights and responsibilities

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

13.1 *Your rights and responsibilities*

- a) 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 plan 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.
- b) The **group** and we are free to choose the law that applies to this **plan**. In the absence of an agreement to the contrary, the law of England and Wales will apply.
- c) You must write and tell us if you change your address.

- d) Each **family member** may make individual claims under the **plan**, which may be without the knowledge of the **lead member** in accordance with our approach to personal data. Only the **group** and we have legal rights under this **plan** and it is not intended that any clause or term of this **plan** should be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999, by any other person including any **lead member** or **family member**. Consequently, the **lead member** remains liable for excesses and shortfalls incurred by a **family member** under the **plan**.
- e) If you pay a contribution to the **group** towards cover for the **lead member** or **family members** (for example by salary deduction or Direct Debit) it does not give you any rights under the **group insurance contract**, which is between the **group** and us.
- f) If your cover under the **group insurance contract** comes to an end you can apply to transfer to another plan.

13.2 PHC and AXA PPP healthcare's rights and responsibilities

- a) We will tell the **group** in writing the date the **plan** starts and any special terms which apply to it.
- b) We can refuse to add a **family member** to the **plan** and we will tell the **lead member** if we do.
- c) The group is responsible for paying the **premium**. 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 **lead member** or any **family members** in the event of a claim. This means that we will assume the rights of **lead members** 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 **plan**. The **lead member** 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 any amount equivalent the amount you could recover from a third party of state healthcare system.
- e) If you break any of the terms of the **plan** which we reasonably consider to be fundamental, we may (subject to 13.2e)) 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 membership to the **plan** ;
 - impose different terms to any cover we are prepared to provide;
 - end your membership to the **plan** and all cover under it immediately.

- f) If you (or anyone acting on your behalf) make a claim under the **plan** knowing it to be false or fraudulent, we can refuse to make benefit payments for that claim and may declare the membership to the **plan** void from the date of the fraudulent claim. 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 any 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 sanctions lists, laws and regulations of the European Union, **United Kingdom**, United States of America or under a United Nations resolution. We will immediately end cover and stop paying claims on the **plan** if you or a **family member** are directly or indirectly subject to economic sanctions, including sanctions against your country of residence. We will do this even if you have permission from a relevant authority to continue cover or premium payments under a policy. In this case, we can cancel your membership to the **plan** or remove a **family member** immediately without notice, but will then tell you if we do this. If you know that you or a **family member** are on a sanctions list or subject to similar restrictions you must let us know within seven days of finding this out.
- h) The **plan** is written in English and all other information and communications to you relating to the **plan** will also be in English.

13.3 *Your **group's** rights and responsibilities*

- a) Your **plan** is for one **year**. At the end of that time, provided the **plan** you are on is still available, the **group** can renew it on the terms and conditions applicable at that time which we shall notify to the **group**. You will be bound by those terms.
- b) Only those people described in the **group insurance contract** can be members of this **plan**.
- c) All cover ends when the **lead member** stops working for the **group** or if the **lead member's** membership of the legal entity ends or if the **group** decides to end the cover. Cover for **family members** ends when the **lead members'** cover ends.

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 the British Acupuncture Council (BAcC); and who, in all cases, meets our criteria for acupuncturists 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.

Agreement – an agreement we have with each of the **private hospitals, day-patient units** and **scanning centres** listed in the **Directory of Hospitals**. Each Agreement sets out the standards of clinical care, the range of services provided and the associated costs.

benefits table – the tables applicable to the **plan** 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.

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

chronic condition ♦ – a disease, illness or injury that has one or more of the following characteristics:

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

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.

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

Directory of Hospitals – a document we publish which lists the **private hospitals**, **day-patient units** and **scanning centres** in the **United Kingdom** covered by the **plan**. The facilities listed may change from time to time so you should always check with us before arranging **treatment**.

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

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

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

facility – a **private hospital** or a 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 **lead member's** current spouse or civil partner or any person (whether or not of the same sex) living permanently in a similar relationship with the **lead member** and 2) any of their or the **lead member's** children. Children cannot stay on your **plan** after the renewal date following their 25th birthday.

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: www.axapphealthcare.co.uk or thepbc.co.uk/phc-members-area/how-to-claim or by contacting the claims line on 0800 068 7111.

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

We will only accept referrals from your NHS GP practice. If you have PHC Plus, we will also accept referrals from a private GP or Doctor@Hand GP.

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

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

homeopath - a medical practitioner with full registration under the Medical Acts, who specialises in homeopathy who is registered under the relevant Act or a practitioner of homeopathy who holds full membership of the Faculty of Homeopathy; 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.

lead member – the first person named on the **plan** Certificate of Cover. If the first person named on the **plan** Certificate of Cover is under 18 then a parent or guardian will be named as the lead member, in this circumstance the lead member will not be entitled to cover under this **plan**.

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

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

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

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

plan – the insurance contract between the **group** and us. Its full terms are set out in the current versions of the following documents as sent to you from time to time:

- the **group insurance contract**
- any application form we ask you to fill in
- these terms and the **benefits table** setting out your cover
- your Certificate of Cover and our letter of acceptance
- any Statements of Fact we have sent you.

Please note:

This Handbook contains the terms and benefits tables for the following products: HealthCover4Life Plan 1, Plan 1a, Plan 2, Plan 2a, Plan 3, Plan 3a, Plan 3b and Plan 4.

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 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.

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

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.

For **out-patient treatment** only:

a medical practitioner with full registration under the Medical Acts, who specialises in musculoskeletal 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 decide these matters is available on request.

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

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



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