



SecureHealth

Care Options 6

**Corporate
Membership handbook
What you need to know**

October 2009

SecureHealth
private medical insurance

Contacting us

While it is important that **you** read and understand this **policy** handbook, **we** understand that it is often easier to call **us** to obtain information – so **we** have a team of Personal Advisers to help **you**. **You** should always call them on 0845 607 6163 when **you** need **treatment** so **we** can help **you** to understand the extent of your cover before **you** incur any **treatment** costs.

Quick reference guide for important information

SecureHealth Customer Helpline 0845 607 6163

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

If your corporate cover ends call 08450 60 80 60

If your corporate healthcare cover ends, **you** can continue with **us** on a personal policy. Just call **our** team of advisers on 08450 60 80 60 to discuss your options.

Available: Monday to Friday 9am to 5pm.

Please see section 11 for full terms and conditions.

Health at Hand 0800 003 004

Available: day or night, 365 days a year.

Our health information service. See page 33.

Calls to all the telephone numbers above may be recorded in case of subsequent query.

We are committed to giving customers access to **our** products. To contact **us** by Typetalk on any of the numbers listed in this handbook just prefix the number listed with 18001.

For example, **our** team of Personal Advisers can be contacted by Typetalk on 18001 0845 607 6163 and 'Health at Hand' can be contacted on 18001 0800 003 004.

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

Contents

Section	Page number
1 Introduction	2
2 Your cover	3
3 Benefits table and Options	5
4 Arranging treatment and making a claim	11
5 Existing medical conditions	14
6 Your cover for certain types of treatment	17
7 Recurrent, continuing and long-term treatment Your cover for cancer treatment.	21 23
8 Where you are covered for treatment	28
9 Who we pay for treatment	30
10 Health at Hand	33
11 Additional information How to add other members. Transferring plans. How an excess is applied to claims.	34
12 Complaint and regulatory information Complaints procedure. How your personal data is protected. Legal rights and responsibilities.	37 39 40
13 Glossary	41

How can I retain my cover if my corporate healthcare scheme ends?

You'll find transferring from a **company** scheme to a personal plan is quick, easy and trouble-free. Join within three months of leaving your **company** scheme and there will be no application form to fill in, no medical examination and **we** will guarantee to cover **you**. **We** will also cover **you** without additional medical underwriting if **you** no longer qualify to be covered under the **company** scheme and are transferring to a **policy** with comparable benefits and restrictions on cover. Your new **policy** will start on the day after your **company** cover ends.

To ensure continuous cover, call **us** on 08450 60 80 60 as soon as **you** know **you** will be leaving your **company** scheme. We'll help **you** decide upon the best personal healthcare plan to suit **you**. Please see section 11 for full terms and conditions.

1 Introduction

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

This handbook sets out the terms of your cover for the SecureHealth Care Options 6 plan. If **you** are unsure of which particular Options **you** have, please refer to your membership statement.

This handbook is an important document as it details:

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

Throughout your handbook certain words and phrases appear in **bold type** to indicate they have a special medical or legal meaning. **You** will find a glossary of these words on pages 41–44.

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

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

2 Your cover

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

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

Summary of the SecureHealth Care Options 6 Plan

The SecureHealth Care Options 6 **policy** offers **you** cover for necessary **treatment** of new **medical conditions** that arise after **you** join. It does not cover **you** for **treatment** of **medical conditions** that existed, or **you** had symptoms of before joining. However, in some circumstances **you** may have joined on a different basis, please refer to the 'Existing medical conditions' section for further information. There is also no cover for ongoing, recurrent and long-term conditions (also known as **chronic conditions**). SecureHealth Care Options is a modular private medical insurance **policy**, so **you** may choose the Options that **you** require. The core benefits are described as 'Option 1 – Standard Cover' which includes cover for:

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

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

'6 Week Option' plans

This is a '6 Week Option' plan, therefore, if the NHS can give **you** the hospital **treatment you** need within six weeks of the date on which the **treatment** should be undertaken, then **you** must use the NHS. Please see page 5 for more information.

continued overleaf

Be aware:

Your policy will not cover you for:	For more information:
Routine pregnancy and childbirth.	Page 20
Charges when treatment is received outside of our Directory of Hospitals .	Page 28
General dental procedures.	Page 17
Urgent or emergency treatment .	Page 12

The key limitations listed below apply if **you** have Option 1 only. Please refer to your **benefits table** for details of how your benefits may have been extended to cover some of these items by choosing additional Options.

Your policy will not cover you for:	For more information:
Out-patient diagnostic tests and out-patient consultations.	Page 8
Out-patient complementary practitioners or clinical practitioners charges (including physiotherapy).	Page 8
Psychiatric treatment .	Page 9

Please note:

We may not always pay charges in full if the person treating has charged outside the range that is usual for that **treatment** in the past. Please see the 'Who we pay for treatment' section of this handbook for full details.

3 Benefits table and Options

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

Please make sure **you** call **us** on 0845 607 6163 prior to **treatment** so **we** can confirm the extent of your cover and any limitations that may apply.

This **policy** will cover the costs of **in-patient** or **day-patient treatment** – or an **out-patient surgical procedure** – if the National Health Service could not provide that **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.

Immediate cover: **We** will pay as per benefit 1 in the Option 1 **benefits table** for the **surgical procedures** shown below whether or not the patient could obtain the **treatment** as an NHS patient within six weeks after the date on which the **treatment** should be undertaken:

- varicose veins surgery
- tonsillectomy
- insertion of grommets
- removal of bunions (hallux valgus)
- removal of gall bladder (laparoscopic cholecystectomy)
- haemorrhoidectomy
- adenoidectomy
- correction of squint
- cataract surgery.

There is no benefit available for urgent or emergency **treatment** or if the National Health Service could provide the **in-patient** or **day-patient treatment** or **out-patient surgical procedure** within six weeks after the date on which the **treatment** should be undertaken.

Option 1 – Standard Cover	
Benefits	Amount payable
In-patient and day-patient treatment	
1. Private hospital and day-patient unit charges. Including charges for accommodation, diagnostic tests , operating theatre charges, nursing care, drugs and dressings, physiotherapy, and surgical appliances used by the specialist during surgery.	Paid in full at a private hospital or day-patient unit listed in the Directory of Hospitals .
For more information on the above please see:	Pages 28–29
2. Private hospital and day-patient unit charges for day-patient treatment of radiotherapy (the use of radiation to treat cancers) and chemotherapy (the use of drugs to treat cancers).	Paid in full
For more information on the above please see:	Pages 28–29
3. Out of directory cash benefit. This benefit is payable if you receive private in-patient or day-patient treatment at a hospital or day-patient unit not listed in the Directory of Hospitals .	£50 each day for day-patient treatment . £50 each night for in-patient treatment .
For more information on the above please see:	Page 28
4. Specialists’ fees (surgeons’, anaesthetists’ and physicians’).	No annual maximum
For more information on the above please see:	Pages 30–32
5. In-patient consultations. Benefit for a consultation with a second specialist arranged by the treating specialist .	No annual maximum
For more information on the above please see:	Pages 30–32
6. Higher hospital cover for in-patient treatment in the United Kingdom . Please note: This will only be applied in the unlikely event that you choose to use a private hospital in the Directory of Hospitals which has higher charges than your policy allows. At the time of going to print there were no such hospitals listed and therefore currently this benefit is not applicable.	£400 a night
For more information on the above please see:	Pages 28–29

Option 1 – Standard Cover (continued)	
Benefits	Amount payable
Out-patient treatment	
7. Surgical procedures.	No annual maximum
For more information on the above please see:	Pages 30–32
8. Radiotherapy (the use of radiation to treat cancers) and chemotherapy (the use of drugs to treat cancers).	No annual maximum
For more information on the above please see:	Pages 23–27
9. (i) Computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET). (ii) Out of directory scanning cash benefit. This benefit is payable for using a CT, MRI or PET facility not listed as a scanning centre in the Directory of Hospitals .	Paid in full in a scanning centre listed in the Directory of Hospitals . £50 each visit
For more information on the above please see:	Pages 28–29
Other benefits	
10. NHS cash benefit. This benefit is paid for each night you receive free treatment under the NHS and only if: (i) you are admitted for in-patient treatment before midnight. (ii) the treatment you receive under the NHS would have been eligible for benefit privately under this policy . There is no requirement for private treatment to have preceded any period in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.	£100 a night up to £2,000 a year .
For more information on the above please see:	Pages 28–29
11. Day-patient and out-patient NHS radiotherapy and chemotherapy cash benefit. This benefit is paid for day-patient or out-patient radiotherapy or chemotherapy you receive free under the NHS for the treatment of cancer and only if the treatment you receive under the NHS would have been eligible for benefit privately under this policy .	£50 a day up to £2,000 a year .
12. Health at Hand. Confidential medical information.	Immediate access 24 hours a day, 365 days a year.
For more information on the above please see:	Page 33

Optional excess information

Excess for each person covered by this **policy** each **year**:

Excess 1 £100 Excess 2 £250

Excesses do not apply to the NHS cash benefit and **day-patient** and **out-patient** NHS radiotherapy and chemotherapy cash benefit.

Option 2 – Limited out-patient	
Benefits	Amount payable
1. Specialist consultations.	These three benefits have a combined overall limit of £1,100 per year .
2. Diagnostic tests on specialist referral.	
3. Clinical practitioner charges.	
For more information on the above please see:	Pages 30–32

Option 3 – Full out-patient	
Benefits	Amount payable
1. Specialist consultations.	No annual maximum
2. Diagnostic tests on specialist referral.	
3. Clinical practitioner charges.	
For more information on the above please see:	Pages 30–32

Option 4 – Therapy treatment	
Benefits	Amount payable
1. Complementary practitioner charges.	These two benefits have a combined overall limit of £1,100 a year .
2. Physiotherapist charges.	
For more information on the above please see:	Pages 30–32

Option 5 – Psychiatric cover	
Benefits	Amount payable
In-patient and day-patient treatment	
1. Private hospital and day-patient unit charges for psychiatric treatment , including charges for accommodation, diagnostic tests and drugs.	Paid in full for up to 28 days a year at a private hospital or day-patient unit listed in the Directory of Hospitals .
For more information on the above please see:	Pages 28–29
2. Specialists’ fees for psychiatric treatment .	No annual maximum
For more information on the above please see:	Pages 30–32

Option 5 – Psychiatric cover	
Benefits	Amount payable
In-patient and day-patient treatment continued	
3. In-patient consultations for psychiatric conditions. Benefit for a consultation with a second specialist arranged by the treating specialist .	No annual maximum
For more information on the above please see:	Pages 30–32
Out-patient treatment	
4. Specialist consultations for psychiatric conditions.	These two benefits have a combined overall limit of £1,200 a year .
5. Clinical practitioners' charges for psychiatric treatment .	
For more information on the above please see:	Pages 30–32

Option 6 – Additional benefits	
Benefits	Amount payable
1. Ambulance transport. When you are receiving private in-patient or day-patient treatment and it is medically necessary to use a road ambulance to transport you between a hospital and another medical facility.	Up to £500 a year .
2. Parent accommodation. This benefit is for the cost of one parent staying in hospital with a child under 11 years old while the child is receiving eligible private treatment . The child must be covered by the policy and the benefit is paid from the child's benefits.	Paid in full
3. Hospital-at-home. This is for treatment provided at home or another clinically appropriate setting for the administration of intravenous chemotherapy for the treatment of cancer or intravenous antibiotics which otherwise would require you to be admitted for in-patient or day-patient treatment .	<p>Paid 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.

continued overleaf

Option 6 – Additional benefits (continued)	
Benefits	Amount payable
<p>4. Oral surgery. This is for treatment of the following oral surgical procedures:</p> <ul style="list-style-type: none"> • replantation 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. 	<p>Paid in full at a facility with which we have an agreement for the provision of oral surgical procedures.</p>
For more information on the above please see:	Page 29

Option 7 – No claims discount

Your employer may have chosen this Option; however, it does not affect the benefits, exclusions or limitations of your **policy**. For further information contact your employer.

Option 8 – Cancer upgrade

Option 1 Standard cover includes cover for the **in-patient, day-patient** and **out-patient treatment** of **cancer**, including radiotherapy. There is also cover for chemotherapy, including where **treatment** is necessary for a prolonged period of time, for up to one year. If **you** have Option 8 this will be covered for up to three years.

For more information on the above please see:

Pages 23–27

4 Arranging treatment and making a claim

To ensure your claim proceeds smoothly, please follow these simple steps.

Step One	Your GP refers you to a specialist for private treatment .
Step Two	You need to call us on 0845 607 6163 to check that the treatment is eligible . Please help us by having the following details available: <ul style="list-style-type: none">• Specialist or group practice name.• Hospital name and any admission dates.• A procedure code if you are having a surgical procedure.
Step Three	We will then: <ul style="list-style-type: none">• Check that we will pay the specialist's fees in full.• Confirm which hospitals, day-patient units and scanning centres are covered.• Send you a partially completed claim form. <p>Please note: Out-patient consultations and diagnostic test are not eligible under this policy unless you have chosen Option 2 or 3.</p>
Step Four	<ul style="list-style-type: none">• Complete your section of the claim form.• Take the claim form with you when you first go for treatment and ask the specialist to complete it and return it to AXA PPP healthcare.
Step Five	Send in any outstanding accounts for treatment to AXA PPP healthcare. If you require further treatment contact us to confirm your cover.

Please send any correspondence to:

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

Please note:

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 on page 5, or **you** are receiving **day-patient** or **out-patient** radiotherapy or chemotherapy).

Be aware:

If **you** ask your GP to complete the claim form they may make a charge, which **we** will not refund.

What happens if I require emergency treatment?

This **policy** will only provide benefit for **in-patient** or **day-patient treatment** and **out-patient surgical procedures** if the NHS cannot provide that **treatment** within six weeks after the date on which the **treatment** should be undertaken.

Be aware:

This means that conditions for which urgent or emergency **treatment** is needed are not covered by the **policy**.

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. Your **policy** therefore will not cover it because of its urgent or emergency nature.

How are my medical bills settled?

We normally receive accounts for **treatment** directly from **specialists** or hospitals.

However, if **you** receive an account for payment, please forward it to **us**. **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**.

What must I provide when making a claim?

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

- **you** or the **policyholder** send **us** a completed claim form or patient's declaration and consent form as soon as possible and no later than six months from the date the **treatment** starts; and
- **we** receive original invoices for **treatment** costs; and
- **you** or the **policyholder** promptly give **us** all the information **we** request.

We reserve the right to change the procedure for making a claim and will write to advise the **policyholder** of any changes.

Do I need to provide any other information?

4.2 It may not always be possible to assess the eligibility of your claim from the claim form (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** refuse to agree to such access **we** will refuse your claim and will recoup any previous monies that **we** paid in respect of that **medical condition**.

- 4.3 At **our** own cost **we** can 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. **We** exercise the right to do this only very rarely in cases where there is uncertainty as to the nature or extent of the **medical condition** and/or liability under the **policy**. **You** must co-operate with any **specialist** chosen by **us** or **we** will not pay your claim.

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

- 4.5 **You** must tell **us** on the claim form or patient's declaration and consent form if **you** can claim any of the cost from anyone else. If benefits are claimed for **treatment to you** when the injury or **medical condition** was caused by some other person (the 'third party'), **we** will pay those benefits **you** can claim under the **policy**.

If another insurance policy covers those benefits then **we** will only pay **our** proper share of the benefits. However, in paying those benefits, **we** obtain both through the terms of the **policy** and by law a right to recover the amount of those benefits from the third party. In this case, the following shall apply:

- **you** must tell **us** as quickly as possible if a third party caused the injury or **medical condition** or if they were at fault. **We** may then write to **you** if **we** require further information; and
- **you** (or your solicitors) must keep **us** fully informed about the progress and outcome of any action; and
- **you** must include all monies paid by **us** in respect of the injuries (and interest on those monies) in your claim against the third party ('**our** outlay'); and
- if **you** decide to claim for damages and have received benefit under this **policy** as a result of any alleged negligence or action of a third party **we** will charge **you** an administration fee of up to £400, excluding VAT. **We** will include the administration fee in the summary of **our** outlay submitted to your opponents. **You** must use all reasonable endeavours to recover the administration fee within your claim; and
- should **you** successfully recover any monies from the third party (whether in full or part settlement) **you** will pay **our** outlay or in the event that **you** recover only a percentage of your claim for damages the same percentage of **our** outlay directly to **us** within 21 days of the recovery. If **you** do not repay to **us** such monies (and any interest), **we** shall be entitled to recover the same from **you**; and
- any global settlement will be deemed to include recovery of **our** outlay in the same proportion as the global settlement bears to the total claim for damages.

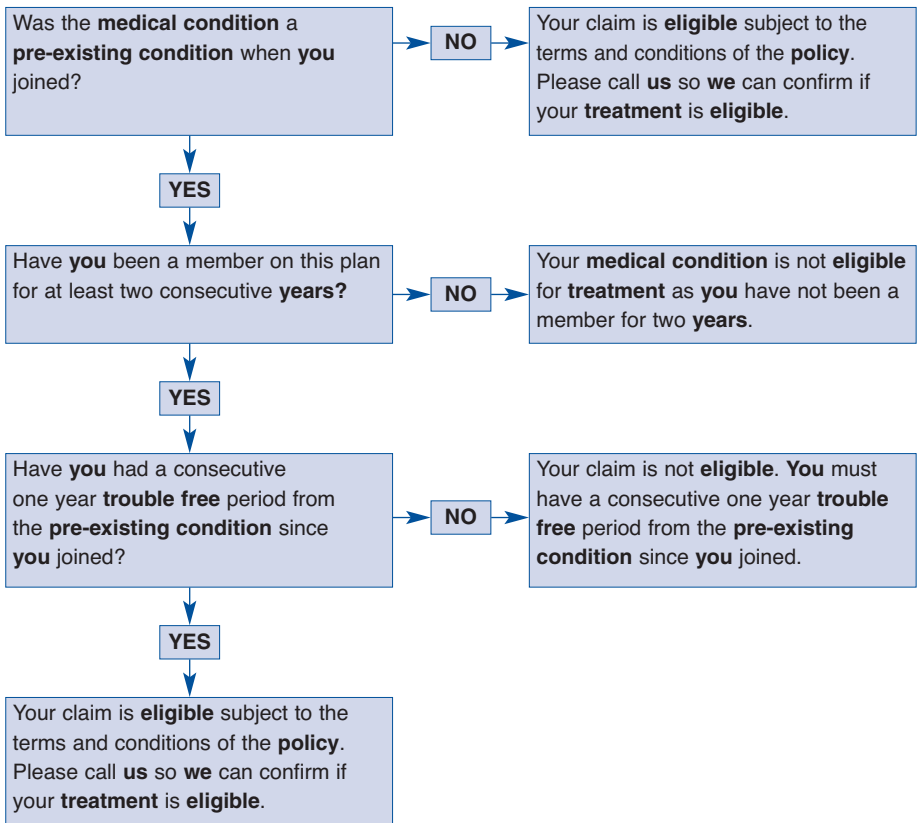
The rights and remedies in this sub-clause are cumulative and not exclusive of rights or remedies provided by law.

5 Existing medical conditions

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

Medical insurance is designed primarily to provide cover for **treatment** of new **medical conditions** that arise after **you** join. This is the usual position. However, **you** may have joined on a different basis in which case that fact will be shown on your membership statement. If **you** completed a medical history declaration when **you** joined, your membership statement will show the **medical conditions** for which **we** will not cover **you** for **treatment** and whether **we** can review that exclusion.

If **you** did not provide your medical history when **you** joined, the following diagram shows how your **policy** works and the process **we** go through when assessing your claim. The **policy** terms are shown on the following page.



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.

trouble free – when **you**:

- have not had any medical opinion from a medical practitioner including GP's or **specialists**; or
- have not taken any medication (including over the counter drugs) or followed a special diet; or
- have not had any medical **treatment**; or
- have not visited a **clinical practitioner** or **complementary practitioner**; for the **medical condition**.

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**.

Once **you** have been a member for two consecutive **years**, **you** may be able to claim for **treatment** of **pre-existing conditions** as long as **you** have had a **trouble free** period of one consecutive year from 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 one year **trouble free** period.

What happens when I want to make a claim?

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

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

Be aware:

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

Please note:

If your employer chooses to upgrade your cover at renewal to include further Options, **we** may apply additional restrictions to those Options.

5.1 **We pay for eligible:**

- (a) **Treatment** of a new **medical condition** that arises after **you** join.
- (b) **Treatment** of **pre-existing conditions** once **you** have been a member for at least two consecutive **years** and have had a consecutive one year **trouble free** period.

5.2 **What we do not pay for:**

- (a) **Treatment** of **pre-existing conditions** for the first two **years** after **you** join.
- (b) If **you** completed a medical history declaration when **you** joined: **we** will not pay for **treatment** of any **medical condition** which **you** already had when **you** joined and which **you** should have told **us** about but did not tell **us** at all or did not tell **us** everything. This includes any such **medical condition(s)** or symptoms, whether or not being treated and any previous **medical condition(s)** which recurs or which **you** should reasonably have known about even if **you** had not consulted a doctor.
- (c) **Treatment** of any other **medical condition** detailed on your membership statement as excluded for benefit.

6 Your cover for certain types of treatment

Will my policy cover me for preventive treatment?

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

Please note:

We do not pay for genetic tests, when those tests are undertaken to establish whether or not **you** may be genetically disposed to the development of a **medical condition**.

What other treatments are not covered?

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

6.1 We pay for eligible:

- (a) **Diagnostic tests** when performed as **in-patient** or **day-patient treatment**.
- (b) **Out-patient** computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET).
- (c) Options 2 or 3 only: **Out-patient diagnostic tests** ordered by a **specialist**.
- (d) Option 6 only: Oral **surgical procedures** listed below following referral by a dentist:
 - replantation 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.
- (e) Initial reconstructive surgery to restore function or appearance after an accident or following surgery for a **medical condition**, provided that:
 - **we** have covered **you** continuously under a **policy** of **ours** since before the accident or surgery happened
 - **we** agree the cost of the **treatment** in writing before it is done (see also 6.2(j)).
- (f) **Treatment** of astigmatism where the astigmatism arises from the surgical replacement of the lens of the eye (see also 6.2(l)).

6.2 What we do not pay for:

- (a) **Diagnostic tests** other than detailed in 6.1(a), 6.1(b) and 6.1(c).
- (b) Any general dental procedure or for orthodontics, or oral **surgical procedures** other than set out in 6.1(d).
- (c) **Treatment** which is not medically necessary or which may be considered a matter of personal choice.
- (d) Any **treatment** of warts of the skin.
- (e) Vaccinations, routine preventive examinations or preventive screening.
- (f) Preventive **treatment**.
- (g) **Out-patient** drugs or dressings.
- (h) If **you** do not have Options 2 or 3: **Out-patient** consultations, **out-patient diagnostic tests** or any other **out-patient treatment** except as detailed in the Option 1 **benefits table**.
- (i) The costs of providing or fitting any external prosthesis or appliance.
- (j) Cosmetic (aesthetic) surgery or **treatment**, or any **treatment** relating to previous cosmetic or reconstructive **treatment**. (See also 6.1(e)).
- (k) 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).
- (l) Any other **treatment** of astigmatism or any other refractive errors. (See also 6.1(f)).
- (m) Any **treatment** to correct long or short-sightedness.
- (n) **Treatment** directed towards developmental delay in children whether physical or psychological or due to learning difficulties.
- (o) 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**.
- (p) Any **treatment** costs incurred as a result of engaging in any sport as a professional.
- (q) 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.
- (r) Claims on this **policy** if **you** live outside the **United Kingdom** or any **treatment** received outside the **United Kingdom**.
- (s) 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 recommended **treatment** is not available under the NHS within six weeks after the date on which the required **treatment** should be undertaken. This requirement shall not apply to those **surgical procedures** listed in the **benefits table** or **day-patient** or **out-patient** radiotherapy or chemotherapy.

Will my policy cover me for new or experimental treatments?

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

Be aware:

There is no cover for any **treatment** or procedure that has not been established as being effective or which is experimental.

6.3 We pay for **eligible**:

- (a) **Surgical procedures** listed in a technical document, called the schedule of procedures, which **we** make available to **specialists** and which lists the **surgical procedures we** pay benefits for. **We** will pay for **treatment** not listed if, before the **treatment** begins, it is established that the **treatment** is recognised as appropriate by an authoritative medical body and **we** have agreed with the **specialist** and the hospital what the fees will be. If **you** would like a copy of the schedule of procedures please refer to the AXA PPP healthcare website: www.axapphealthcare.co.uk
- (b) Reasonable costs incurred for a live donor to donate an organ or tissue provided that:
 - the operations to both the donor and the recipient are carried out simultaneously; and either
 - both the donor and the recipient are immediate relatives (ie parent, child or sibling) and either the donor or the recipient is covered on this **policy**; or
 - both the donor and the recipient are members of AXA PPP healthcare at the time the operations are carried out and both have been members since before the recipient developed the **medical condition** requiring the transplant. (See also 6.4(b)).

6.4 What **we** do not pay for:

- (a) The use of a drug or **treatment** which has not been established as being effective or which is experimental. For drugs this means they must be licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and be used within the terms of that licence.
- (b) The cost of collecting donor organs or tissue or for any related administration costs (such as, but not limited to, the cost of a donor search).

Childbirth, pregnancy and sexual health

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

Be aware:

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

6.5 **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**
 - failure to progress in labour.

6.6 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, contraception, assisted reproduction, sterilisation (or its reversal) or any consequence of any of them or of any **treatment** for them.
- (c) **Treatment** of impotence or any consequence of it.
- (d) Gender re-assignment operations or any other surgical or medical **treatment** including psychotherapy or similar services which arise from, or are directly or indirectly associated with gender re-assignment.

7 Recurrent, continuing and long-term treatment

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

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

We define a **chronic condition** in the glossary on page 41 as:

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

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

Please note:

Your **policy** will cover **you** for the following phases of **treatment** for a **chronic condition** (subject to the restrictions on this **policy** for **out-patient treatment** if **you** do not have Options 2 or 3):

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

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

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

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

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

We publish a leaflet which explains how **we** deal with payment for **treatment** of **chronic conditions**. This is available on **our** website: www.axapphealthcare.co.uk and can also be

obtained from **us**. **You** will also find further explanation of how **we** deal with payment for **cancer treatments** on page 23.

7.1 **We** pay for **eligible**:

- (a) **Treatment** of an **acute condition** and the short-term **in-patient treatment** intended to stabilise and bring under control a **chronic condition**.
- (b) Kidney dialysis for up to six weeks during preparation for kidney transplant.
- (c) Initial diagnosis and immediate **treatment** of HIV infection, when **we** will pay **in-patient treatment** benefit for one stay of up to 28 days.
- (d) **In-patient** rehabilitation of up to 28 days when it is an integral part of **treatment**; and
 - it is carried out by a **specialist** in rehabilitation
 - it is carried out in a recognised rehabilitation hospital or unit which is either listed in the **Directory of Hospitals** or which **we** have written to confirming it is recognised by **us**
 - the costs have been agreed by **us** before the rehabilitation begins.**We** will extend **in-patient** rehabilitation to a maximum of 180 days in cases of severe central nervous system damage caused by an external trauma.
- (e) Hormone replacement therapy (HRT) only when it is medically indicated for the **treatment** of menopause resulting from medical intervention, when **we** will pay for the **specialist** consultations and for the cost of the implants (but not patches or tablets). **We** will only pay benefits for a maximum of 18 months from the date of the medical intervention.

7.2 What **we** do not pay for:

- (a) Ongoing, recurrent or long-term **treatment** of any **chronic condition**.
- (b) The monitoring of a **medical condition**.
- (c) Any **treatment** which only offers temporary relief of symptoms rather than dealing with the underlying **medical condition**.
- (d) Routine follow-up consultations.
- (e) Regular or long-term kidney dialysis in the case of chronic kidney failure.
- (f) **Treatment** of any **medical condition** which arises in any way from HIV infection once the initial diagnosis has been made.
- (g) Any hormone replacement therapy (HRT) except for the **treatment** of menopause resulting from medical intervention.

What cover do I have for psychiatric treatment?

Option 5: **you** have cover for the **treatment** of psychiatric illness, subject to all other benefit limitations and exclusions on your **policy**.

In-patient and **day-patient treatment** of psychiatric illness is limited to an overall maximum of 28 days for each person covered each **year**.

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

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

If **you** do not have Option 5 there is no benefit available for **treatment** of psychiatric illness.

7.3 We pay for eligible:

- (a) Option 5 only: **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.

7.4 What we do not pay for:

- (a) If **you** do not have Option 5: any **treatment** of psychiatric illness.
- (b) **Treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide.
- (c) **Treatment** of, or **treatment** which arises from or is in any way connected with, alcohol abuse, drug abuse or substance abuse.

Will my policy cover me for cancer treatment?

You are covered for **treatment** of a new **cancer** which arises after **you** join and for any recurrence of this **cancer**. If **you** have exclusions because of your past medical history which relate to a **cancer**, then **you** will not be covered for any recurrence of **cancer**. Please refer to section 5 on page 14 for further information on your cover for pre-existing **medical conditions**.

Your **policy** covers the investigation and **treatment** intended to affect the growth of the **cancer** by shrinking it, stabilising it or slowing the spread of disease. This includes surgery, radiotherapy or chemotherapy, alone or in combination.

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

Please note:

This cover is subject to the restrictions on this **policy** on:

- **out-patient treatment**
- any urgent or emergency **treatment**
- **treatment** that is available under the NHS within six weeks after the date on which the required **treatment** should be undertaken.

NHS or private?

Whilst **you** are covered for **eligible cancer treatment** on this **policy** **you** may decide that **you** want to receive **treatment** on the NHS. If **you** are diagnosed with **cancer** **you** will be

referred to one of **our** nurse case managers. They will be able to give **you** information on the **treatment** options open to **you** and support **you** through your **treatment**.

Should **you** choose to receive your **treatment** as an NHS patient **you** will be **eligible** to receive the NHS cash benefits shown in the **benefits table** on page 7, when **you** receive **eligible day-patient** or **out-patient** radiotherapy or chemotherapy or **eligible in-patient treatment**. **Our** nurse case managers will also be able to discuss other services which **we** can arrange, to support **you** whilst **you** are receiving NHS **cancer treatment**, for example transport assistance, childcare or domestic help.

The following table is a summary of the cover provided for **cancer** under this **policy** and should be read alongside the rest of the handbook, including the **benefits table** on pages 5–10.

Summary of Cancer cover for SecureHealth Care Options 6		
	Cover	
Where am I covered for treatment?	✓	Treatment of cancer at a private hospital, day-patient unit or scanning centre listed in our Directory of Hospitals .
	✗	Charges made for the treatment of cancer at a private hospital, day-patient unit or scanning centre not listed in the Directory of Hospitals .
	✓	Intravenous chemotherapy received at home in the circumstances shown on the benefits table on page 9.
	✗	Treatment received at a hospice.
What cover do I have for diagnostic procedures?	✓	In-patient and day-patient : • consultations with a specialist ; and • diagnostic tests .
	✓	Surgical procedures as shown below.
	✓	CT, MRI and PET scans.
	✓ If you have Options 2–3	Out-patient consultations with a specialist and out-patient diagnostic tests ordered by a specialist , subject to any out-patient benefit limits.
	✗ If you do not have Options 2–3	There is no cover for out-patient consultations with a specialist and out-patient diagnostic tests .
✗	Genetic screening required to establish a genetic pre-disposition to certain forms of cancer .	

Summary of Cancer cover for SecureHealth Care Options 6 (continued)

	Cover	
What cover do I have for surgical treatment?	✓	<p>Surgical procedures for the treatment or diagnosis of cancer, as shown on page 16 when that treatment has been established as being effective.</p> <p>At the time of going to print the NHS was commonly providing treatment of cancer within six weeks and therefore it is unlikely that there will be cover on this policy for such surgical treatment.</p>
	✗	Experimental or unproven surgery. Please refer to the 'Your cover for certain types of treatment' section on page 17 for further information.
Am I covered for preventive treatment?	✗	<p>Preventive treatment, for example:</p> <ul style="list-style-type: none"> • Screening undertaken as a preventive measure where there are no symptoms of cancer. For example, if you receive genetic screening, the result of which shows a genetic predisposition to breast cancer, you would not be covered for the screening or a prophylactic mastectomy to prevent the development of breast cancer in the future. • Vaccines to prevent the development or recurrence of cancer, for example vaccinations for the prevention of cervical cancer.
What cover do I have for drug therapy?	✓	Chemotherapy 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>Chemotherapy treatments that are given for prolonged periods of time. Such prolonged treatment normally falls outside benefit but in the case of cancer we make an exception (subject to the limits detailed below). This includes drugs, such as Herceptin for some types of breast cancer and Avastin for some types of colon cancer.</p> <p>The cover provided by this policy for prolonged chemotherapy treatment is payable once per course of cancer treatment. By 'course of cancer treatment' we mean from diagnosis of a primary or secondary cancer (whichever occurs first) through to the final surgery, radiotherapy or chemotherapy for that primary or secondary cancer (whichever occurs last).</p>

continued overleaf.

Summary of Cancer cover for SecureHealth Care Options 6 (continued)

	Cover	
	If you have Option 8	<p>These drug treatments will be covered for up to:</p> <ul style="list-style-type: none"> • three years of such treatment; or • the period of the drug licence whichever is the shorter. <p>The time limit starts from when you first started receiving the drug treatment funded by us.</p> <p>These drugs will be eligible for benefit provided they are used within the terms of their licence.</p>
	If you do not have Option 8	<p>These drug treatments will be covered for up to:</p> <ul style="list-style-type: none"> • one year of such treatment; or • the period of the drug licence whichever is the shorter. <p>The time limit starts from when you first started receiving that drug, however it may have been funded.</p> <p>In any event, these drugs will only be eligible for benefit when they are used within the terms of their licence and in circumstances where they are proven to be effective treatments.</p>
	x	<p>Drug treatment given to prevent a recurrence of cancer, for the maintenance of remission or where its use is continuing without a clear end date. Such ongoing treatments are not eligible although, if they are given by injection, we would pay for up to three months to allow the treatment to be established.</p>
	x	<p>Out-patient drugs and drugs prescribed by your GP. For example, hormone therapy tablets (such as Tamoxifen) are out-patient drugs and therefore are not covered by our policies.</p>
Am I covered for radiotherapy?	✓	Radiotherapy, including when used to relieve pain.
Am I covered for terminal care?	x	There is no cover for terminal care, wherever carried out.
Am I covered for monitoring?	✓ If you have Options 2–3	Follow up consultations and reviews of cancer will be covered for 10 years from your last surgery, chemotherapy or radiotherapy for that cancer , subject to any out-patient benefit limits.
	x If you do not have Options 2–3	Monitoring of cancer usually takes place during out-patient consultations which are not covered by this policy . Therefore you do not have cover for the monitoring of cancer .

Summary of Cancer cover for SecureHealth Care Options 6 (continued)

	Cover	
Am I covered for bone marrow or stem cell treatment?	✓	Stem cell treatment and bone marrow treatment , including the reasonable costs incurred for a live donor to donate bone marrow or stem cells as shown on page 19, section 6.3(b).
	✗	Any related administration costs (such as, but not limited to, transport costs and the cost of a donor search).

8 Where you are covered for treatment

Which hospitals and day-patient units do I have cover for?

The **Directory of Hospitals** lists the hospitals and **day-patient units** in the **United Kingdom** for which **we** provide cover. **We** have chosen these **hospitals** based on the quality, value and range of services that they provide and **we** have an **Agreement** with them under which they will provide services to **our** customers.

Please note:

If **we** are unable, after reasonable negotiation, to conclude the **Agreement** in whole or part, it may be necessary from time to time for **us** to suspend the use of a hospital, **day-patient unit** or **scanning centre** listed in the **Directory of Hospitals** so as to protect the interests of all **our** customers. In such an event **we** will indicate the suspension on **our** website: www.axapphealthcare.co.uk

Be aware:

From time to time part of the **Agreement** may be that **we** will cover charges in full at certain **private hospitals**, because those hospitals have higher charges than your **policy** allows. In such an event, if **you** choose to receive **in-patient treatment** in one of those hospitals, then **we** will only pay the cash benefit shown in the Option 1 **benefits table**. To be assured of cover, please call **our** team of Personal Advisers in advance of any **treatment**.

If it is medically necessary for **you** to use a hospital, **day-patient unit** or **scanning centre** not listed in the **Directory of Hospitals** or one which would be outside your cover and **we** have specifically agreed to this in writing before the **treatment** begins then **we** will pay those hospital charges.

We also have specific arrangements in regard to **eligible** cataract and oral **surgical procedures** as detailed on the next page.

What happens if I choose to have treatment at a hospital which is not in the Directory of Hospitals?

If **you** have **in-patient** or **day-patient treatment** in any private hospital which **we** do not list in the **Directory of Hospitals** then **we** will pay **you** only a small cash benefit shown in the Option 1 **benefits table**. **You** will be entirely responsible for paying the hospital bills.

If **you** have **eligible in-patient treatment** as a National Health Service (NHS) patient incurring no charges at all, then **we** will pay any NHS cash benefit shown in the Option 1 **benefits table**.

Which scanning centres and out-patient facility charges are covered?

Your **policy** includes cover for computerised tomography (CT), magnetic resonance imaging (MRI) scans and positron emission tomography (PET). If **you** require CT, MRI or PET **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**.

We will pay for **eligible** charges made by a provider **we** have an agreement with for the use of their facilities on an **out-patient treatment** basis (which may include charges for the use of drugs).

If **you** use a **scanning centre** that is not listed in the **Directory of Hospitals**, then **we** will only pay the cash benefit shown in the Option 1 **benefits table**.

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

If **you** have Option 6 **we** will pay for those oral **surgical procedures** detailed in 6.1(b) when your dentist refers **you** directly to a **facility** with which **we** have an agreement to provide a range of oral **surgical procedures**.

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

Please note:

We recommend that **you** call **us** prior to receiving any **treatment** to ensure that the **treatment** **you** need will be covered.

8.1 We pay for eligible:

- (a) Charges made by, or incurred in, a **private hospital** or any NHS hospital for ITU (Intensive Therapy Unit, sometimes called Intensive Care Unit) **treatment** only when ITU **treatment** immediately follows **eligible** private **treatment** and **you** or your next of kin have asked for the ITU **treatment** to be received privately.
- (b) NHS cash benefit, as shown on the Option 1 **benefits table**, for each night **you** receive free **treatment** in an NHS intensive therapy unit or NHS intensive care unit

8.2 What we do not pay for:

- (a) Any charges from health spas, nature cure clinics or any similar place, even if it is registered as a hospital.
- (b) Special nursing in hospital unless **we** have agreed beforehand that it is necessary and appropriate.
- (c) Any charges made by, or incurred in an NHS hospital for ITU **treatment**, except as allowed for by 8.1(a).

9 Who we pay for treatment

Your **policy** can provide benefit for **eligible treatment** provided by **specialists**. Additionally, Options 2 and 3 provide benefit for **eligible treatment** provided by **clinical practitioners** and Option 4 provides benefit for **eligible treatment** provided by **complementary practitioners** and **physiotherapists**.

How do I find out whether the person I want to see for treatment is recognised?

You need to call **us** before receiving any **treatment**. This will allow **us** to check **our** database and confirm whether the person **you** have been referred to is **eligible** for benefit.

In addition, **you** could check the AXA PPP healthcare website: www.axapphealthcare.co.uk which provides relevant information about the **specialists we** recognise.

What services provided by specialists, complementary practitioners, clinical practitioners and physiotherapists are eligible for benefit?

If you have:	Option 1 Standard Cover	Option 2 and 3	Option 4	
We will pay for charges for treatment from:	Specialists*	Clinical practitioners	Complementary practitioners	Physiotherapists
If you are referred by your GP	✓	✗	✓ Please see limits below	✓ Please see limits below
If you are referred by a specialist	✓	✓	✓	✓
If you are referred by your dentist	✓	✗	✓	✗

*Includes consultations, **diagnostic tests**, **treatment** in hospital and **surgical procedures**.

Will treatment charges be met in full?

We pay in full the fees of most **specialists**, **clinical practitioners**, **complementary practitioners** and **physiotherapists** as they charge fees within the range that is usual for the **treatment** they provide. **We** will continue to pay these fees in full provided that the **specialist**, **clinical practitioner**, **complementary practitioner** or **physiotherapist** continues to charge fees within the range that is usual.

Please note:

You can call **our** team of Personal Advisers for confirmation that the person **you** want to see will have their **eligible** charges met in full. **You** may also check **our** website: www.axapphealthcare.co.uk which provides information on the **specialists** that **we** recognise. In order to ensure cover remains affordable, **we** have identified those **specialists, clinical practitioners, complementary practitioners** and **physiotherapists** who make charges to **our** customers that exceed the range that is usual and **we** treat them as '**capped practitioners**'. If **you** receive **eligible treatment** from a **capped practitioner** **we** will limit benefit to the average **we** have been charged for that **treatment**.

Will I have to pay towards my treatment if I receive treatment from a capped practitioner?

Be aware:

You need to call **us** to confirm whether the person **you** want to see is a **capped practitioner**. If they are, **we** will tell **you** how much **we** will pay towards the cost of your **treatment**. **We** recommend **you** then obtain an estimate of their charges so **you** can determine whether **you** need to pay anything yourself. Where **you** have to pay towards your **treatment**, the amount may be significant.

What if an anaesthetist becomes involved in my treatment?

When **you** tell **us** which **specialist** **you** intend to see **we** will make every effort to notify **you** whether they commonly work with an anaesthetist who is a **capped practitioner**. If this is the case **you** should establish which anaesthetist your **specialist** intends to use so **we** can tell **you** how much **we** will pay towards the **treatment** charges of that anaesthetist.

9.1 We pay for **eligible**:

- (a) **Treatment** charges made by a **capped practitioner** at the average charge or at the amount charged if lower than the average. The average charge is the sum of all the charges for that type of **treatment** made by all the **specialists, clinical practitioners, complementary practitioners** and **physiotherapists** divided by the number of such charges.
- (b) **Treatment** charges in full when they are made by a **specialist, clinical practitioner, complementary practitioner** or **physiotherapist** not referred to in 9.1(a) as long as they charge fees within the range that is usually charged by **specialists, clinical practitioners, complementary practitioners** and **physiotherapists** for that **treatment**.

9.2 What we do not pay for:

- (a) Charges made by a **specialist** or **complementary practitioner** when **you** have been referred to them by a member of your family, or if that **specialist** or **complementary practitioner** is a member of your family.
- (b) **Treatment** charges made by a **capped practitioner** above the average amount charged by **specialists, clinical practitioners, complementary practitioners** and **physiotherapists** for that **treatment**.
- (c) **Treatment** charges made by a **specialist, clinical practitioner, complementary practitioner** or **physiotherapist** not referred to in 9.1(a) in excess of the usual amount charged by **specialists, clinical practitioners, complementary practitioners** and **physiotherapists** for that **treatment**.
- (d) Charges for general chiropody or foot care even if this is carried out by a surgical podiatrist.
- (e) Any charges made for written reports or any other administrative costs.

10 Health at Hand

How could Health at Hand help me?

Health at Hand is a telephone based multi-clinic information service, so you will have the reassurance of immediate access to a qualified and experienced team of healthcare professionals 24 hours a day, 365 days a year.

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

Please note:

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

Health at Hand can help you make informed choices day or night

Whether you are calling because you have late night worries about a child's health or you have some questions that you forgot to ask your GP, it's likely that Health at Hand will be able to provide you with the help you need. Here are just a few examples of the range of topics you can discuss at each of the clinics:

Family Clinic – babies, toddlers, teenage trouble, pregnancy or retirement.

Care and Counselling Clinic – stress, addiction, depression or bereavement.

Healthy Living Clinic – exercise, diet, drinking, smoking and cholesterol control.

Travel Clinic – inoculations, taking children abroad and medical advice by country.

Pills and Prescriptions Clinic – medicines, side effects and pain relief.

Women's Health Clinic – fertility, screenings, menopause and osteoporosis.

Men's Health Clinic – prostate issues, testicular cancer, impotence and fertility.

Health at Hand – 0800 003 004

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

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

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

11 Additional information

When can I add other members?

If **you** want to join or add **family members** to your **policy** **we** will send **you** the forms to complete fully with the information **we** request. Depending on your agreement with your employer, there may be restrictions on when **you** can add **family members** to your **policy**. Please contact **us** for details.

How can I retain my cover if I leave my corporate healthcare scheme?

If **you** no longer qualify to be covered under the **company** scheme, because for example, **you** change jobs or retire, **we** guarantee to cover **you** if **you** join an individual plan with **us** within three months.

You'll find transferring from a **company** scheme to a personal plan arranged by SecureHealth within the **policy year** is quick, easy and trouble free. Join within three months of leaving and **we** will guarantee to cover **you**. There will be no application form to fill in and no medical examination and **we** will also cover **you** without additional medical underwriting if **you** no longer qualify to be covered under the **company** scheme and are transferring to a plan with comparable benefits and restrictions. Your new **policy** will start on the day your **company** cover ends.

Please remember that your entitlement to benefits under your personal **policy** will be subject to the terms and conditions of the product **you** choose and the level of benefits may differ from those on your corporate **policy**.

To ensure continuous cover, call **us** on 08450 60 80 60 as soon as **you** know **you** will be leaving your **company** scheme. We'll help **you** decide upon the best personal healthcare plan to suit **you**.

Can I add my new baby to my policy?

You can apply to add newborn babies (who are born to the **policyholder** or the **policyholder's** partner) to the **policy** from their date of birth. This can normally be done without filling out details of their medical history provided **you** add them within three months of their date of birth. However, **we** will require details of the baby's medical history if the baby has been adopted or was born as the result of any method of assisted conception. In such circumstances **we** reserve the right to apply particular restrictions to the cover **we** will offer and may decline to offer cover in the first three months following birth for babies born as the result of any method of assisted conception.

Will I have to pay income tax on the premiums

Yes, membership of the **policy** will give rise to a liability for income tax on the premiums paid by your employer.

Can I cancel my policy?

No, this group scheme has been purchased by your employer so **you** do not have any right to cancel the group scheme.

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

If **you** have an excess on your **policy**, this is what it means and how it is applied:

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

Please see example overleaf.

If you have an excess, here is an example of how the excess operates:

Example 1 – SecureHealth Care Options with Options 1 and 2 with £100 excess	
	This policy has a benefit limit of £1,100 (for each person each year) for out-patient consultations, and diagnostic tests and clinical practitioners’ charges.
One	You develop a medical problem and require £700 of eligible diagnostic tests – your first claim for that policy year .
Two	The £100 excess charge is applied.
Three	We pay £600 towards the £700 cost of out-patient treatment , while you pay the £100 excess.
Four	This £700 total claim reduces your £1,100 benefit limit for out-patient consultations, diagnostic tests and clinical practitioners’ charges to £400.
Then...	Later in the same policy year , you suffer a different medical condition , incurring costs of £450 for eligible out-patient consultations and diagnostic tests – £50 more than the policy’s remaining £400 benefit limit.
So...	We pay £400 towards the cost of treatment , and you pay the £50 shortfall.

12 Complaint and regulatory information

What should I do if I have reason to complain?

We aim to provide **you** with courteous, efficient service.

Providing **you** with clear and accurate information – whether in writing or by telephone – is an important part of **our** service. **Our** team of Personal Advisers is there to guide **you** through your AXA PPP healthcare membership. They can help **you** when **you** are making a claim – as well as remind **you** of restrictions **you** may have on your **policy** (please remember that **our** policies are not intended to cover all eventualities).

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.

Step one

If **you** think things have gone wrong for **you** and **you** are unhappy with **us**, please contact **our** team of Personal Advisers in the first instance and they will try to resolve your complaint.

Step two

If **you** are unhappy with their response, then **we** invite **you** to contact **us**, preferably in writing, to:

Customer Relations Executive

AXA PPP healthcare

Phillips House

Crescent Road

Tunbridge Wells TN1 2PL

We will acknowledge your complaint upon receipt, investigate it and respond to **you** within 10 working days of receiving your letter (**we** will, of course, keep **you** informed if there is an unavoidable delay).

Step three

If **you** are dissatisfied with this response then **we** invite **you** to write, detailing why **you** feel **our** decision is incorrect in relation to the terms and benefits of your **policy**, to:

The Operations Director

AXA PPP healthcare

PPP House

Vale Road

Tunbridge Wells TN1 1BJ

Again **we** will acknowledge your letter upon receipt. **Our** Operations Director will – on behalf of **our** Chief Executive – review your complaint and respond to **you** within 20 working days of receiving your letter (**we** will, of course, keep **you** informed if there is an unavoidable delay).

Step four

The Financial Ombudsman Service will review your complaint if **you** remain dissatisfied after **we** have issued **our** final decision from the Operations Director. The address **you** need to write to is:

The Financial Ombudsman Service, South Quay Plaza, 183 Marsh Wall, London E14 9SR

Telephone: 0845 080 1800

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

Website: www.financial-ombudsman.org.uk

The Ombudsman will review complaints about:

- the way in which your **policy** was sold to **you**
- the administration of your **policy**
- 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 usually review a complaint where:

- **we** gave a final decision over six months ago
- your case already involves (or has involved) legal action.

None of these procedures affect your legal rights.

What regulatory protection do I have?

The Financial Services Authority (FSA)

AXA PPP healthcare is authorised and regulated by the Financial Services Authority (FSA). The FSA was established by government to provide a single statutory regulator for financial services. The FSA is committed to securing the appropriate degree of protection for consumers and promoting public understanding of the financial system.

The FSA have set out rules which regulate the sale and administration of general insurance which **we** must follow when **we** deal with **you**. **Our** FSA register number is 202947.

This information can be checked by visiting the FSA register which is on their website: www.fsa.gov.uk/register or by contacting the FSA on 0845 606 1234.

We provide advice and 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), a body established by the FSA. The scheme is governed by FSA 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.

For non-compulsory insurance the scheme pays the first £2,000 of a valid claim in full and 90% of the remaining amount of your loss.

Further information about the operation of the scheme is available on the FSCS website: www.fscs.org.uk

How is my personal data protected?

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

SecureHealth and AXA PPP healthcare limited will deal with all personal information supplied to **us** in the strictest confidence as required by the Data Protection Act (1998). **We** may send personal and sensitive personal information in confidence for processing by other companies and intermediaries, including those located outside the European Economic Area. **We** extend the same duty of confidentiality to any third parties to whom **we** may subcontract the administration of your **policy**, including those based outside the European Economic Area.

SecureHealth and AXA PPP healthcare limited will hold and use information about **you** and any **family members** covered by your **policy**, supplied by **you**, those **family members**, medical providers or your employer (if applicable) to provide the services set out under the terms of this **policy**, administer your **policy** and develop customer relationships and services. In certain circumstances **we** may ask medical service providers (or others) to supply **us** with further information.

When **you** give **us** information about **family members** **we** will take this as confirmation that **you** have their consent to do so. As the **policyholder** is acting on behalf of any **family member** covered by this **policy**, AXA PPP healthcare limited will send all correspondence about the **policy**, including any claims correspondence, to the **policyholder** unless **we** are advised to do otherwise.

We are required by law, in certain circumstances, to disclose information to law enforcement agencies about suspicions of fraudulent claims and other crime. **We** will disclose information to third parties including other insurers for the purposes of prevention or investigation of crime including reasonable suspicion about fraud or otherwise improper claims. This may involve adding non-medical information to a database that will be accessible by other insurers and law enforcement agencies. Additionally, **we** are obliged to notify the General Medical Council or other relevant regulatory body about any issue where **we** have reason to believe a medical practitioner's fitness to practise may be impaired.

If **you** have agreed, SecureHealth may use the information **you** have provided to **us** to contact **you** by post, telephone or electronically with details of other products and services. With your agreement **we** may also share some of your details with other SecureHealth Group companies and other carefully selected companies based in the European Economic Area to enable them to contact **you** about their products and services and, if appropriate, to administer them. If **you** change your mind please contact the SecureHealth Customer Helpline or write to **us** at the address on the back of this handbook, otherwise **we** will assume that, for the time being, **you** are happy to be contacted in this way.

12.1 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 **policy** or apply different terms of cover in line with the terms **we** would have applied had the information been presented to **us** fairly in the first place.
- (b) **You** and **we** are free to choose the law that applies to this **policy**. In the absence of an agreement to the contrary, the law of England and Wales will apply.
- (c) **You** must write and tell **us** if **you** change your address.
- (d) Only the **policyholder** and **we** have legal rights under this **policy** and it is not intended that any clause or term of this **policy** should be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999, by any other person including any **family member**.
- (e) If your cover under the **company agreement** comes to an end **you** can apply to transfer to another **policy**.

12.2 AXA PPP healthcare's rights and responsibilities

- (a) **We** will tell the **policyholder** in writing the date the **policy** starts and any special terms which apply to it.
- (b) **We** can refuse to add a **family member** to the **policy** and **we** will tell the **policyholder** if **we** do.
- (c) **We** will pay for **eligible** costs incurred during a period for which the premium has been paid.
- (d) If **you** break any of the terms of the **policy** **we** can:
 - 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; and
 - refuse to renew your **policy**; or
 - impose different terms to any cover **we** are prepared to provide; or
 - end your **policy** and all cover under it immediately.
- (e) This **policy** is written in English and all other information and communications to **you** relating to this **policy** will also be in English.

12.3 Your company's rights and responsibilities

- (a) Your **policy** is for one **year**. At the end of that time, provided the **policy** **you** are on is still available, the **company** can renew it on the terms and conditions applicable at that time which **we** shall notify to **you**. **You** will be bound by those terms.
- (b) Only those people described in the **company agreement** can be members of this **policy**.
- (c) All cover ends when the **policyholder** stops working for the **company** or if the **company** decides to end the cover.

13 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.

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

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

capped practitioner – a **specialist, complementary practitioner, clinical practitioner** or **physiotherapist** whose fees **we** will reimburse only at the average amount charged for the **treatment** (or the actual amount of the fees if lower), subject always to the other terms of your **policy**.

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.

clinical practitioner – a practising member of certain professions allied to medicine who, in all cases, meets **our** recognition criteria for benefit purposes in their field of practice and who **we** have told in writing that **we** currently recognise them as a **clinical practitioner** for benefit purposes.

However, **we** will only pay **out-patient treatment** benefits for such services when a **specialist** refers **you** to them.

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.

company – your employer.

company agreement – an agreement **we** have with the **company** which allows the **policyholder** to be registered as the **policyholder**. This agreement sets out who can be covered, when cover begins, how it is renewed, and how the premiums are paid.

complementary practitioner – a medical practitioner with full registration under the Medical Acts, who specialises in homeopathy or acupuncture or a practitioner in osteopathy or chiropractic who is registered under the relevant Act; and who, in all cases, meets **our** criteria for **complementary practitioner** recognition for benefit purposes in their field of practice, and who **we** have told in writing that **we** currently recognise them as a **complementary practitioner** 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.

day-patient ♦ – a patient who is admitted to a hospital or **day patient unit** because they need a period of medically supervised recovery but does not occupy a bed overnight.

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

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

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

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

facility – a **private hospital** or 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 **policyholder's** current spouse or civil partner or any person (whether or not of the same sex) living permanently in a similar relationship with the **policyholder** and (2) any of their or the **policyholder's** unmarried children. Unmarried children cannot stay on your **policy** after the renewal date following their 21st birthday (or 25th birthday if in full-time education).

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

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

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

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

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

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

- any application form **we** ask **you** to fill in
- these terms and the **benefits table** setting out your cover
- your membership statement and **our** letter of acceptance
- the **Directory of Hospitals**.

policyholder – the first person named on the **policy** membership statement.

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

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

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

Out-patient treatment only:

a **medical practitioner** with full registration under the Medical Acts, who specialises in psycho-sexual medicine, 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.

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

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.

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.

we/us/our – AXA PPP healthcare.

year – twelve calendar months from when your **policy** began or was last renewed.

you – the **policyholder** and any **family member** named on the **policyholder's** membership statement.



SecureHealth is an intermediary which acts as your general agent and accepts responsibility for the advice provided and arrangement of your insurance.

SecureHealth Limited,

Link House, 62 High Street,

Billericay, Essex CM12 9BS

Tel: 08450 60 80 60

Fax: 08450 60 90 60

www.securehealth.co.uk

info@securehealth.co.uk

Authorised and regulated by the Financial Services Authority

Underwritten and administered by AXA PPP healthcare limited.

AXA PPP healthcare limited.

Registered Office: 5 Old Broad Street, London EC2N 1AD, United Kingdom.

Registered in England No. 3148119.

Authorised and regulated by the Financial Services Authority.



PB34996a/10.09