

Private Medical Insurance

Corporate Healthcover*4*life

Handbook

April 2024

Claims line

0800 068 7111

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

24 hour medical help and information

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

0800 027 1393

Leaving your group

Stay covered with the same personal medical underwriting

Call AXA Health on 0800 533 5962

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

If you have hearing, speech or visual difficulties

www.thephc.co.uk/stand-alone-pages/accessibility

This gives helpful information and support on how to access your documentation and different ways to communicate with us.

This handbook and other literature can be provided in Braille, large print or digital audio, please contact us

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1 Quick-start guide to your membership

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

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

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

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

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

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

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

- 1.1 > Your cover
- 1.2 > Extra cover from the 'Plus' optional upgrade
- 1.3 > The main things we don't cover
- 1.4 > Ask our health professionals
- 1.5 > Counselling and Support Service

Words and phrases in bold type

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

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

You and your

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

We, us and our

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

1.1 > Your cover

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

Benefit Table for HealthCover4 <i>life</i>		
If you're an in-patient or day-patient		
<p>Private hospital and day-patient unit fees</p>	<p>✓ Paid in full so long as you use a hospital or day-patient unit in our Directory of Hospitals</p>	<p>Including fees for in-patient or day-patient:</p> <ul style="list-style-type: none"> ▪ accommodation ▪ diagnostic tests ▪ using the operating theatre ▪ nursing care ▪ drugs ▪ dressings ▪ physiotherapy ▪ surgical appliances that the specialist uses during surgery. <p>» For details, see 3.7</p>
<p>Cash payment if you use a hospital or day-patient unit that is not in our Directory of Hospitals</p>	<p>✓ £50 a night for in-patient treatment ✓ £50 a day for day-patient treatment</p>	<p>If you have private in-patient treatment or day-patient treatment at a private hospital or day-patient unit that is not in our Directory of Hospitals.</p> <p>» For details, see 3.7</p>
<p>Specialist fees</p>	<p>✓ No yearly limit</p>	<p>Includes fees for:</p> <ul style="list-style-type: none"> ▪ surgeons ▪ anaesthetists ▪ physicians. <p>» For details, see 3.6</p>
<p>Private hospital and day-patient unit fees for psychiatric treatment</p>	<p>✓ Plan 1: up to 45 days a year ✓ Plan 2: up to 28 days a year ✓ Plan 3: up to 28 days a year ✗ Plan 4: no cover</p>	<p>So long as you use a hospital or day-patient unit in our Directory of Hospitals. Including fees for:</p> <ul style="list-style-type: none"> ▪ accommodation ▪ diagnostic tests ▪ drugs. <p>» For details, see 3.7</p>

Benefit Table for HealthCover4life

Accommodation for one parent while their child is in hospital	✓ Paid in full	Covers the cost of one parent staying in hospital with their child. The child must be covered by your membership and having treatment covered by it.
Hotel accommodation for one close relative or friend while a member is in hospital	✓ Up to £100 a night up to £500 a year	Covers towards the costs for one close relative or friend to stay near to the private hospital where a member is having treatment . The member must have treatment covered by the plan and the purpose of the hotel stay must be to provide support to the member. We will not take any excess off this cash payment.
If you're an out-patient		
Surgery	✓ No yearly limit	» For details, see 3.7
CT, MRI or PET scans	✓ Paid in full at a scanning centre , or hospital listed as a scanning centre , in our Directory of Hospitals	A specialist must refer you. CT = Computerised Tomography MRI = Magnetic Resonance Imaging PET = Positron Emission Tomography » For details, see 3.7
Specialist consultations and practitioner fees when your specialist refers you	<ul style="list-style-type: none"> ✓ Plan 1: no yearly limit ✓ Plan 2: no yearly limit ✓ Plan 3: no yearly limit ✓ Plan 4: two specialist consultations a year 	This includes remote consultations by telephone or via a video link instead of you going to an out-patient clinic. This benefit does not include specialist consultations or practitioner fees for psychiatric illness.
Diagnostic tests performed by your specialist or when your specialist refers you	✓ No yearly limit	

Benefit Table for HealthCover4*life*

The following four benefits have a combined overall yearly limit of:

Plan 1: No yearly limit

Plan 2: £1,500 a year

Plan 3: £1,000 a year

Plan 4: £500 a year

Fees for **out-patient treatment** by **physiotherapists**

Within these limits when on GP referral or when you have **physiotherapist** or **osteopath treatment** through our muscles, bones and joints service **treatment** can include:

Plan 1:

Up to an overall maximum of 20 sessions in a **year** with a **physiotherapist** and up to 20 sessions in a **year** with a **therapist** or **acupuncturist**;

Plan 2, Plan 3, Plan 4:

Up to an overall maximum of 10 sessions in a **year** with a **physiotherapist** and up to 10 sessions in a **year** with a **therapist** or **acupuncturist**;

and for all Plans:

Further sessions when your **specialist** refers you as long as we agree them first.

Fees for **out-patient treatment** by **therapists** or **acupuncturists**

Specialist consultations for psychiatric illness

✘ Plan 4: No cover

This includes remote consultations by telephone or via a video link instead of you going to an **out-patient** clinic.

Psychiatric **treatment** by psychologists or psychotherapists

✘ Plan 4: No cover

Benefit Table for HealthCover4life

Other benefits

<p>Cash payment when you have free treatment under the NHS</p>	<ul style="list-style-type: none"> ✓ Plan 1: £200 a night up to £6,000 a year ✓ Plan 2: £100 a night up to £2,000 a year ✓ Plan 3: £100 a night up to £2,000 a year ✓ Plan 4: £100 a night up to £2,000 a year 	<p>We pay this when:</p> <ul style="list-style-type: none"> ▪ you are admitted for in-patient treatment before midnight; and ▪ we would have covered your treatment if you had had it privately. <p>You can also receive this cash payment if you have treatment in an NHS Intensive Therapy or Intensive Care unit, whether it follows private treatment or not. If you have an excess, we will not take this off this cash payment.</p>
<p>Cash payment when you have free day-patient treatment under the NHS</p>	<ul style="list-style-type: none"> ✓ Plan 1: £150 per claim ✓ Plan 2: £50 per claim ✓ Plan 3: £50 per claim ✓ Plan 4: £50 per claim 	<p>We pay this when:</p> <ul style="list-style-type: none"> ▪ we would have covered your treatment if you had had it privately.
<p>Cash payment if you have chemotherapy or radiotherapy free on the NHS</p>	<ul style="list-style-type: none"> ✓ Plan 1: £50 a day up to £2,000 a year ✓ Plan 2: £50 a day up to £2,000 a year ✓ Plan 3: £50 a day up to £2,000 a year ✗ Plan 4: No cover 	<p>If you choose to have day-patient or out-patient chemotherapy or radiotherapy to treat cancer on the NHS. We will only pay this if the treatment would have been covered by your membership. If you have an excess, we will not take this off this cash payment.</p> <p>» For details, see 4.1</p>
<p>External prosthesis</p>	<ul style="list-style-type: none"> ✓ Up to £5,000 for the lifetime of your membership 	<p>We will pay this benefit towards the cost of providing an external prosthesis.</p> <p>If you have an excess, we will not take this off this cash payment.</p> <p>» For details, see 4.11</p>

Benefit Table for HealthCover4life

<p>AXA Doctor at Hand</p>	<p>✓ Unlimited video or telephone consultations through the AXA Doctor at Hand service</p>	<p>Access to the AXA Doctor at Hand service for video or telephone consultations. For information on terms and conditions, registering and how to use this service, please visit: axahealth.co.uk/onlinegpservice/register</p> <p>» For details, see Section 2 Making a claim</p> <p>If you have an excess, we will not take this off this benefit.</p>
<p>New child benefit</p>	<p>For each child born or adopted:</p> <p>✓ Plan 1: £200 ✓ Plan 2: £100 ✓ Plan 3: £100 ✗ Plan 4 – No cover</p>	<p>One of the parents named on the birth certificate must have been covered on the plan for 10 or more months in a row before the birth or adoption.</p> <p>You will need to send us an original or certified copy of the long birth certificate or adoption papers.</p>
<p>Ambulance transport</p>	<p>✓ Plan 1: Paid in full ✓ Plan 2: £250 a year ✓ Plan 3: £250 a year ✗ Plan 4: No cover</p>	<p>If you are having private in-patient or day-patient treatment and it is medically necessary to use a road ambulance to transport you to another medical facility.</p>
<p>Nurse to give you antibiotics by intravenous drip at home</p>	<p>✓ Paid in full</p>	<p>We will pay for treatment:</p> <ul style="list-style-type: none"> ▪ at home or ▪ somewhere else that is appropriate. <p>We will pay for a nurse to give you antibiotics by intravenous drip.</p> <p>This is so long as:</p> <ul style="list-style-type: none"> ▪ we have agreed the treatment beforehand; and

Benefit Table for HealthCover4*life*

		<ul style="list-style-type: none"> ▪ you would otherwise need to be admitted for in-patient or day-patient treatment; and ▪ the nurse is working under the supervision of a fee approved specialist; and ▪ the treatment is provided through a healthcare services supplier that we have a contract with for this kind of service.
Home nursing	<ul style="list-style-type: none"> ✓ Plan 1: No yearly limit ✓ Plan 2: No yearly limit ✓ Plan 3: No yearly limit ✗ Plan 4: No cover 	<p>We will pay for the fees for a qualified nurse when:</p> <ul style="list-style-type: none"> ▪ nursing is provided under the direction of the treating specialist for medical reasons; and ▪ it immediately follows in-patient or day-patient treatment.
Hospice cash benefit	<ul style="list-style-type: none"> ✓ Plan 1: £75 a day up to a maximum of 15 days for the lifetime of your membership ✓ Plan 2: £75 a day up to a maximum of 15 days for the lifetime of your membership ✓ Plan 3: £75 a day up to a maximum of 15 days for the lifetime of your membership ✗ Plan 4: No cover 	<p>We will pay this when you are at the terminal stage of cancer.</p>

Benefit Table for HealthCover4life

<p>Hospice donation</p>	<ul style="list-style-type: none"> ✓ Plan 1: £75 a day up to a maximum of 15 days for the lifetime of your membership ✓ Plan 2: £75 a day up to a maximum of 15 days for the lifetime of your membership ✓ Plan 3: £75 a day up to a maximum of 15 days for the lifetime of your membership ✗ Plan 4: No cover 	<p>We will pay a charitable donation to a hospice providing care in the terminal stage of cancer.</p>
<p>Recuperative care. This is to cover the services of:</p> <p>(i) a nurse for secondary nursing care; or</p> <p>(ii) a care assistant for the following personal care services:</p> <p>Household duties</p> <ul style="list-style-type: none"> • washing • cooking • cleaning • general household chores • shopping • preparing meals. <p>Help with personal hygiene</p> <ul style="list-style-type: none"> • washing and bathing • eating and drinking • dressing and undressing • using the toilet. 	<ul style="list-style-type: none"> ✓ Plan 1: up to a maximum of £500 a year ✗ Plan 2: No cover ✗ Plan 3: No cover ✗ Plan 4: No cover 	<p>We will pay when the recuperative care:</p> <ul style="list-style-type: none"> ▪ is received in the 90 days after your date of discharge following in-patient treatment that the plan covers; and ▪ is certified by your GP or specialist as being necessary because of your medical or domestic circumstances; and ▪ if the claim is for household these tasks would normally be carried out by the person claiming the benefit.

1.2 > Extra cover from the 'Plus' optional upgrade

The following benefit table shows you the cover under the 'Plus' upgrade option. If your cover includes this option it will be confirmed on your Certificate of Cover.

Benefit Table for Plus upgrade		
If you're an in-patient or day-patient		
Private hospital and day-patient unit fees	<p>✓ Paid for a private hospital or day-patient unit not in our Directory of Hospitals up to the normal daily rates</p>	<p>Including fees for in-patient or day-patient:</p> <ul style="list-style-type: none"> ▪ accommodation ▪ diagnostic tests ▪ using the operating theatre ▪ nursing care ▪ drugs ▪ dressings ▪ physiotherapy ▪ surgical appliances that the specialist uses during surgery. <p>» For details, see 3.7</p>
Specialist fees	<p>✓ Fee-limited specialists fees paid full</p>	
If you're an out-patient		
Routine out-patient management of specified chronic conditions	<p>✓ No yearly limit</p>	<p>We will pay for the routine follow-up consultations and associated diagnostic tests (but not out-patient drugs and dressings) with a specialist for the purpose of monitoring the on-going control of a specified chronic condition.</p>
Fees for visits to a private GP for consultations and minor GP surgery	<p>✓ Up to £500 a year</p>	

1.3 > The main things we don't cover

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

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

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

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

The plan does not cover	For more information	Notes
Pregnancy and childbirth	» For details, see 4.23 or call us on 0800 068 7111	Few health insurance plans cover pregnancy and childbirth because they are not illnesses, and the NHS is set up to deal with them.
Treatment of medical conditions you had, or had symptoms of, before you joined	» For details, see 3.4	The plan is designed to cover necessary treatment of new medical conditions that arise after you join.
Treatment of ongoing, recurrent and long-term conditions (chronic conditions)	» For details, see 3.5	Plus upgrade members only: you have some cover for the out-patient management of certain specified chronic conditions
Members who do not have the 'Plus' upgrade: Fees if you choose to use a hospital that is not in our Directory of Hospitals	» For details, see 3.7	If you choose to use a different hospital for private treatment that would have been covered by the plan , we may pay you a small cash payment. We use a Directory of Hospitals as it helps us to keep subscriptions affordable. » See the PHC Directory of Hospitals
Plan 1a, Plan 2a, Plan 3a, Plan 3b and Plan 4 members: Psychiatric treatment	» For details, see 4.20	
Dental treatment	» For details see 4.32	

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

1.4 > Ask our health professionals

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

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

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

Call with your health queries any time – just ask

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

24/7 health support line

0800 027 1393

24 hours a day, 365 days a year.

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

The health professionals

- nurses
- counsellors
- midwives
- pharmacists.

Health Information you can trust

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

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

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

Visit our website

axahealth.co.uk/health

The health professionals

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

24/7 support for cancer and heart

Speak to our specialist cancer and heart nurses

Call the claims line on

0800 068 7111

9am – 5pm Monday to Friday

Outside of these hours our experienced nurses and counsellors provide round the clock support by phone

0800 027 1393

The health professionals

- dedicated nurses.

1.5 > Counselling and Support Service

Sometimes daily life can seem full of challenges.

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

As a PHC member you and any family members (over the age of 16) have access to a comprehensive counselling and support service provided by AXA Health Services Limited.

If you are feeling upset, worried or stressed or have a medical concern, qualified counsellors are on hand to support you. They will help you to explore and understand

your issues and provide guidance and action which could include self-help or face-to-face counselling where clinically appropriate.

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

Counselling and Support Service

Personal Support

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

Face-to-face counselling

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

Counselling via email

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

LifeManagement™ support

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

Online portal

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

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

To speak to someone please call

0800 316 1213

24 hours a day, 7 days a week

Access the online portal:

axabesupported.co.uk

Username: phc

Password: supported

The counselling and support service is only available to members aged 16 years and over.

2 Making a claim

1 Ask your GP for an open referral

We will accept referrals from the AXA Doctor at Hand service or a GP at your GP practice. If your GP says you need specialist treatment, tell them you want to go private and ask for an 'open referral'.

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

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

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

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

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

The AXA Doctor at Hand service - consultations by video or by phone

The AXA Doctor at Hand service offers you cover for video or phone consultations and can refer you for private specialist treatment.

Appointments available 24 hours a day, seven days a week, 365 days a year (subject to appointment availability).

When you contact the AXA Doctor at Hand service, you may be offered an appointment with a GP or another registered medical practitioner.

You can use the AXA Doctor at Hand service for any medical condition or concern, whether or not this would be covered under the other benefits of the plan. You should be aware that there are some conditions that can't be assessed online, so you may need to make an appointment with your GP instead. The service cannot help in an emergency. You should call an NHS ambulance or go to an NHS A&E department.

If the medical practitioner at the AXA Doctor at Hand service says you need treatment, you must call us to check that the treatment is covered.

Private prescriptions and delivery

If the AXA Doctor at Hand service has prescribed medication, this can be delivered to an address of your choice. Private prescription and delivery charges are not covered by the plan.

About the AXA Doctor at Hand service terms

When you use the AXA Doctor at Hand service, you agree to the terms and conditions of the third party providing the service. You will be asked to review and confirm you agree to these when you register.

If you want to claim for muscle, bone and joint pain – no GP referral needed

If you have muscle, bone or joint pain you can get access to advice and treatment without the need for a GP referral. As soon as you develop a problem, just call the claims line on 0800 068 7111 or visit axahealth.co.uk/muscles-bones-joints.

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

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

This service is only available to members aged 18 years or over.

Mental health assessments and support service

This provides prompt access to mental healthcare and support.

Step 1

Call us on 0800 068 7111. If you experience stress, anxiety or any mental health concerns, call the claims line to check your cover. You don't need to get a referral from your GP before you call, but we may ask you to provide more information to help us assess whether the claim is covered, for example when our plan excludes treatment for conditions you had before you joined. This additional information may include us asking for information from your GP.

If you are covered, we will pass you straight through to the service or arrange for you to be called back.

Step 2

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

Step 3

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

** only counselling arranged through the service is covered by the plan.*

The mental health assessment and support service will also provide ongoing clinical case management, as required, to monitor clinical outcomes.

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

This service is only available to members aged 18 years or over.

Self-referral service

There are some conditions that we offer a self-referral service for. This means you do not need a GP referral. If you are concerned about:

- any marks or moles on your skin
- symptoms or changes in your breast(s)
- raised prostate specific antigen test (PSA)

Call us on 0800 068 7111. We will check your cover and take you through some questions designed to show whether the service can help.

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

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

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

For menopausal symptoms – that cannot be managed by your GP

If you need to be referred to a specialist by your GP for the treatment of menopausal symptoms. Call us on 0800 068 7111 – and we will check your cover.

We recommend referral to a specialist accredited by the British Menopause Society (BMS). Please ask your GP for an open referral and we can support you in finding a BMS specialist, either nearby, or one who commonly offers online appointments.

How we pay claims

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

How do you pay my medical bills?

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

» For more details, see 5.2

Do I need to tell the place where I have my treatment that I have private medical insurance?

Yes you must tell the place where you have your **treatment** that you have private medical insurance. This will mean that the fees charged for your **treatment** are those we have agreed with the hospital or centre.

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

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

You should send us any receipts for **treatment** within 6 months after you've had your **treatment**, unless this is not reasonably possible.

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

What should I do if I need further treatment?

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

The information we may need when you make a claim

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

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

What does 'more detailed medical information' mean?

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

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

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

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

What if my treatment isn't covered?

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

What if I want to see a specific specialist?

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

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

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

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

What happens if I need emergency treatment?

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

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

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

» For more details, see the [benefits table](#)

3 How your membership works

- 3.1 > Looking at who should provide treatment
- 3.2 > Eligible treatment
- 3.3 > Our cover for treatment and surgery
- 3.4 > How your membership works with pre-existing conditions and symptoms of them
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- 3.6 > Paying the specialists and practitioners that treat you
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How your membership works

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

Any questions?

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

Making a claim

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

3.1 > Looking at who should provide treatment

Your membership provides access to the AXA Doctor at Hand service for video or phone consultations.

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

3.2 > Eligible treatment

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

'**Eligible treatment**' is **treatment** of a medical condition that is covered by this **plan** and is not excluded by any of the rules in this handbook.

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

3.3 > Our cover for treatment and surgery

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

What do you mean by conventional treatment?

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

is established as best medical practice and is practised widely in the **UK**. It must also be clinically appropriate in terms of necessity, type, frequency, extent, duration and the **facility** or location where the **treatment** is provided.

In addition, to meet our definition, it must be approved by NICE (The National Institute for Health and Care Excellence) as a **treatment** which may be used in routine practice. Otherwise, it must have high quality clinical trial evidence proving it is effective and safe for the **treatment** of your **medical condition** (full criteria available on request).

Are there any restrictions on what you pay for conventional treatment?

Yes. There may be more than one **conventional treatment** available for your **medical condition**. We will only pay for **conventional treatment** that doesn't cost more than an equivalent **conventional treatment** that gives a similar clinical or diagnostic outcome.

For example, if robotic **surgery** is more expensive than an equivalent **surgery**, we will only pay the higher cost if the robotic **surgery** will give a better clinical outcome.

You can choose to go ahead with the more expensive **surgery** or **treatment** even if there is no evidence it will give a better clinical outcome. If you do this, it will be your responsibility to pay any difference between the two costs.

Are there any additional requirements for drug treatments?

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

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

If there is more than one brand of the same drug that will treat your **medical condition**, we will pay for the lowest cost drug. We will only pay for an equivalent higher cost drug if there is evidence that drug will give a better clinical outcome.

Are there any additional requirements for surgical treatments?

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

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

Are there any additional requirements for medical devices?

If the **treatment** involves a medical device (including surgical devices and implants), it must be approved by current EU Medical Device Regulation. When we say medical device we mean any instrument, implant or other item that the manufacturer intended to be used for humans. Medical devices must have moderate or high quality evidence that they are safe and effective from either:

- systematic reviews of randomised controlled trials; or
- clinical trial evidence with three years of follow-up data.

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

We know our members may want to have access to developing **treatments** as they become available. Our general position is that there is no cover for **treatment** or **surgery** that are not **conventional treatment**. We call this **unproven treatment**.

In some cases we will consider covering **surgery** not listed in the schedule of procedures and fees. We may also consider other **treatments** and **diagnostic tests** carried out by a **specialist** which are not **conventional treatments**. We must agree to the **treatment** before you have it, including what costs (if any) we will pay.

The cover for **unproven treatment** is more restrictive than for **conventional treatments**. We will only pay for **treatment** that we agree is a suitable equivalent to **conventional treatment**. To understand what the equivalent **conventional treatment** is we will look at the **treatment** of other patients with the same **medical condition** and prognosis. **Unproven treatment** must have high quality evidence of its safety and take place in the UK.

Are there restrictions on what you pay for unproven treatment?

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

There is no cover for any costs if you are having **treatment** as part of a registered clinical trial.

If we agree to pay for your **unproven treatment**, the most we will pay is up to the amount we would pay for the equivalent **conventional treatment**. This is based on the UK average amount that we would pay a **fee approved specialist** and hospital in the **Directory of Hospitals**.

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

Yes, you or your **specialist** must contact us at least 10 working days before you have **unproven treatment**. This is so we can get the full details of the **treatment** and the clinical evidence. We can also support you with additional information and questions for your **specialist** before you have **treatment**.

There will be no cover for **unproven treatment** if you do not contact us at least 10 days before you book your **treatment**. You cannot pay for **unproven treatment** yourself and reclaim the costs from us.

We recommend you check with the hospital, **specialist**, anaesthetist and other providers how much they will charge for your **treatment**. Some **unproven treatments** can be expensive and it will be your responsibility to pay any shortfall.

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

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

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

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

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

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

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

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

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

- you have received medication, advice or **treatment** in the five years before the start of your cover, or
- you have experienced symptoms of in the five years before the start of your cover: whether or not the condition was diagnosed.

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

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

- FMU = Fully underwritten (or full medical underwriting)
- CPME = Continuing personal medical exclusions

- MHD = Medical history disregarded
- MORI = Moratorium)
- VAR = various. This means that you and your dependants have different underwriting terms applied to them.

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

Fully underwritten or full medical underwriting

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

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

Continuing personal medical exclusions

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

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

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

Medical history disregarded

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

Moratorium

If you joined us on moratorium terms, you won't have cover for **treatment** of any conditions you had in the five years before you joined. This includes if you had symptoms of a condition that hadn't been diagnosed. Once you've been trouble-free from that condition for at least two years in a row after you joined, we can start covering **treatment** of these conditions.

If you joined us from another health insurer or a company membership you might have joined on different moratorium terms. Your membership certificate will show some details about how your moratorium works.

The definition of trouble-free

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

We count you as trouble-free when you haven't seen a medical practitioner, including a GP or **physiotherapist**, or had any **treatment** or advice for your condition for two years. You can't have taken any medication, including over the counter drugs, or followed a special diet because of your condition.

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

There are some other specified conditions that we won't cover **treatment** for if you had diabetes or raised blood pressure when you joined. We won't cover the conditions below no matter what caused them and even if they develop after you join.

If you were having **treatment** or being monitored as a result of having a Prostate Specific Antigen (PSA) test when you joined, we won't cover any prostate conditions.

Pre-existing conditions when you joined:	Specified conditions we do not cover
Diabetes	We will not cover treatment for: <ul style="list-style-type: none">▪ diabetes▪ reduced blood supply to the heart muscle (ischaemic heart disease)▪ cataracts▪ damage to the retina of the eye caused by diabetes (diabetic retinopathy)▪ kidney disease caused by diabetes (diabetic renal disease)▪ disease of the arteries▪ stroke.

<p>If you have had treatment for raised blood pressure (hypertension) in the five years before you joined</p>	<p>We will not cover treatment for:</p> <ul style="list-style-type: none"> ▪ raised blood pressure ▪ reduced blood supply to the heart muscle (ischaemic heart disease) ▪ stroke ▪ kidney failure as a result of high blood pressure (hypertensive renal failure).
<p>If you have been investigated, monitored or treated as a result of a Prostate Specific Antigen (PSA) test in the five years before you joined</p>	<p>We will not cover treatment for:</p> <ul style="list-style-type: none"> ▪ Any disorder of the prostate.

You may be able to claim for these specified conditions once you've been **trouble-free** from the **pre-existing condition** for at least two years in a row after you joined.

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

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

This includes any **pre-existing condition**, whether you had **treatment** for it or not. It also includes any previous **medical condition** that comes back and any **medical condition** that you should reasonably have known about. It doesn't matter if your condition has been diagnosed or not.

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

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

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

Like most health insurance, your membership is designed to cover unexpected illness and conditions that respond quickly to **treatment (acute conditions)**. This means that it may not cover you for **treatment** of conditions that are likely to last a longer time or come back (**chronic conditions**). However, there are particular situations where we can cover **treatment** for these kinds of conditions.

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

Your membership does not cover you for conditions that:

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

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

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

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

Extra cover if you have the 'Plus' optional upgrade

If you have the Plus upgrade, you also have cover for the routine **out-patient** management of **specified chronic conditions**. Please see below for more details.

What are acute conditions and chronic conditions?

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

Acute condition

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

Chronic condition

A **chronic condition** is a disease, illness or injury that has one or more of the following characteristics:

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

What happens if a condition I have is a chronic condition?

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

How does this affect my cover for cancer treatment?

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

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

We also make an exception for treating some heart conditions.

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

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

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

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

What other treatment is covered for chronic conditions?

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

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

Are there any conditions that are always regarded as chronic?

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

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

Extra cover if you have the 'Plus' optional upgrade

If you have the Plus upgrade you have extended cover for **out-patient** routine follow-up consultations and associated **diagnostic tests** (but not **out-patient** drugs and dressings) with a **specialist** for the purpose of monitoring the on-going control a **specified chronic condition**, these are; angina, asthma, diabetes, epilepsy, heart valve problems, high blood pressure, glaucoma, osteoarthritis, rheumatoid arthritis, thyroid problems or ulcerative colitis.

3.6 > Paying the specialists and practitioners that treat you

Does my plan cover the full fees charged by specialists?

If your **treatment** is covered, we will pay different amounts depending on what kind of arrangement we have with your **specialist**.

- **Fee-approved specialist.** Using a **fee-approved specialist** gives you the maximum reassurance, as we pay all their fees. If we book your appointment for you we will book it with a **fee-approved specialist**.
- **Fee-limited specialist.** You may need to pay some costs yourself.
- **Specialists** we do not pay for. We do not pay any of their costs.

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

Very occasionally the arrangement we have with a **specialist** may change, for example a **fee-approved specialist** may move to the **fee-limited specialist** category. This means that what we will pay for **treatment** with that **specialist** may also change. It's important you contact us before you see the **specialist** or have any **treatment** so that we can tell you what you're covered for.

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

Fee-approved specialists – what we pay

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

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

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

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

Fee-limited specialists – what we pay

We still pay **fee-limited specialists**, but you may also need to pay some costs yourself. So long as your **treatment** is covered we will still pay some of the fees for a **fee-limited specialist**. However, we will only pay up to the amount we show in the schedule of procedures and fees. This means that you will probably need to pay something towards the cost of your **treatment**.

When you call to make your claim, we can tell you what you may need to pay for that particular **specialist**. However, you may also want to ask them for a quote before starting **treatment** to make sure you know what you may need to pay.

Schedule of procedures and fees

This is a list of the fees that we pay.

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

What extra cover is there with the 'Plus' upgrade option?

If you have the Plus upgrade you have extra cover for the costs of **treatment** from **fee-limited specialists**. We will pay their fees in full.

Specialists we do not pay for

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

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

What about anaesthetists?

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

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

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

What extra cover is there with the 'Plus' upgrade option?

If you have the Plus upgrade you have extra cover for the costs of **treatment** from **fee-limited specialists** including anaesthetists. We will pay their fees in full.

Specialist appointment booking service

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

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

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

We will pay for **out-patient diagnostic tests** up to the level shown in our schedule of procedures and fees.

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

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

- **nurse**
- dietician
- orthoptist
- speech therapist
- audiologist

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

- psychologist
- psychotherapist

We will pay so long as:

- a **fee-approved** or **fee-limited specialist** is directing your **treatment**
- your **specialist** refers you.

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

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

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

Which therapies do you cover?

We will pay **out-patient treatment** fees up to the levels shown in the benefits table for **treatment** with **physiotherapists, acupuncturists, osteopaths and chiropractors**.

You need to see a **therapist** or **acupuncturist** that we recognise. **Treatment** needs to be referred by a GP or for physiotherapy we can arrange **treatment** for you through our muscles, bones and joints service.

As long as your **treatment** is covered we will pay:

- Plan 1: an overall maximum of 20 sessions in a **year** with a **physiotherapist** and 20 sessions in a **year** for **treatment** with a **therapist** or **acupuncturist**.
- Plan 2, Plan 3, Plan 4: an overall maximum of 10 sessions in a **year** with a **physiotherapist** and 10 sessions in a **year** for **treatment** with a **therapist** or **acupuncturist**.

If your **specialist** or our muscles, bones and joints service refers you, we may agree to more sessions, but will need to agree them first.

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

We pay **physiotherapists, osteopaths and chiropractors (therapists)**, in full if we recognise them. This is so long as they do not charge a significant amount more than they usually do, unless we have agreed this beforehand. All **therapists** used by our muscles, bones and joints service will be recognised by us.

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

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

3.7 > Paying the places where you're treated

Where can I have treatment?

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

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

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

- accommodation
- **diagnostic tests**
- using the operating theatre
- nursing care
- drugs

- dressings
- radiotherapy and chemotherapy
- **physiotherapy**
- surgical appliances that the **specialist** uses during **surgery**.

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

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

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

» See next page for more details about these

What you must tell the place where you have your treatment

You must tell the place where you have your **treatment** that you have private medical insurance. This will help to ensure that the fees charged for your **treatment** are those we have agreed with the hospital or centre.

Where can I have out-patient treatment?

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

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

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

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

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

What about intensive care?

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

- you are already having private **treatment** that is covered by your membership; and
- the intensive care **treatment** immediately follows the private **treatment** that was covered by your membership; and
- you or your next of kin have asked for you to have the intensive care **treatment** privately; and
- we have agreed the costs before you start the intensive care **treatment**.

If you need intensive care **treatment**, you or your **specialist** should call us on 0800 068 7111 before you are admitted to intensive care so we can tell you if you are covered.

Where can I have cataract surgery?

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

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

Where can I have oral surgery?

We will pay for oral **surgery** at any **facility** that we have an agreement with covering oral **surgery**. These are shown in the **Directory of Hospitals**. Your dentist will need to refer you for the **treatment**.

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

Does my plan cover payment for treatment anywhere else?

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

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

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

✓ Extra cover if you have the 'Plus' upgrade option

If you have the Plus upgrade you have extra cover for **treatment** at hospitals, **day-patient units** and **scanning centres** that are not in our **Directory of Hospitals**. As long as your **treatment** is covered we will pay for you to have it at any hospital, **day-patient unit**, **out-patient facility** or **scanning centre** in the UK.

✓ Extra cover if you have the London Upgrade option

If you have the London Upgrade option you have extra cover for **treatment** at certain hospitals, **day-patient units** and **scanning centres** in London. As long as your **treatment** is covered we will pay for you to have it at a hospital, **day-patient unit**, **out-patient facility** or **scanning centre** listed in the London Upgrade section of the **Directory of Hospitals**. If you have this option it will be shown on your Certificate of Cover.

What about treatment on the NHS?

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

» For more details, see the benefits table

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.9 > General restrictions

High charges

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

- a **specialist** in our fee-approved category
- a **physiotherapist**
- an **osteopath**
- a **chiropractor**
- a **practitioner**.

Treatment and referrals by family members

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

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

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

- 4.1 > Cancer
- 4.2 > Advanced therapy medicinal products (ATMPs)
- 4.3 > Alcohol abuse, drug abuse, substance abuse
- 4.4 > Breast reduction
- 4.5 > Chiropody and foot care
- 4.6 > Contraception
- 4.7 > Cosmetic treatment, surgery or products
- 4.8 > Criminal activity
- 4.9 > Drugs and dressings
- 4.10 > Dialysis
- 4.11 > External prosthesis or appliances
- 4.12 > Eye conditions
- 4.13 > Fat removal
- 4.14 > Gender reassignment or gender confirmation
- 4.15 > Genetic tests
- 4.16 > GP and primary care services
- 4.17 > Infertility and assisted reproduction
- 4.18 > Learning and developmental disorders
- 4.19 > Mechanical heart pumps (Ventricular Assist Devices (VAD) and Artificial Hearts)
- 4.20 > Mental health
- 4.21 > Nuclear, biological or chemical contamination and war risks
- 4.22 > Organ or tissue transplant
- 4.23 > Pregnancy and childbirth
- 4.24 > Preventative treatment and screening tests
- 4.25 > Reconstructive surgery
- 4.26 > Rehabilitation

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

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

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

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

Any questions?

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

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

4.1 > Cancer

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

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

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

About your cover for cancer treatment

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

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

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

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

Experienced nurses and case managers

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

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

Cash payment for NHS treatment

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

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

Cancer treatment at home

We will pay in full for a **nurse** from a healthcare services supplier that we have a contract with to give you **treatment** to kill **cancer** cells. You can have this **treatment** at home or another place that is appropriate. This could be chemotherapy by intravenous drip, an injection, delivery of oral chemotherapy tablets or other **treatment**. Your **cancer treatment** needs to be under the supervision of a **specialist** and we must agree to it first.

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

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

How does cancer cover affect out-patient cover?

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

Comparing our cancer cover

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

Place of treatment	Am I covered?
Private hospitals, day-patient units or scanning centres listed in our Directory of Hospitals	✓ Yes
Private hospitals, day-patient units or scanning centres not listed in our Directory of Hospitals	✓ Yes, if you have the Plus upgrade
Drug treatment for cancer at home or somewhere else that is appropriate.	✓ Yes
Diagnostic	Am I covered?
Whether you are an in-patient, day-patient or out-patient	
Diagnostic surgery as shown below under ' Surgery '.	✓ Yes
CT, MRI and PET scans.	✓ Yes
Genetic testing proven to help choose the best eligible treatment . » See section 4.24 for more information on genetic tests.	✓ Yes
Genetic testing to work out whether you have a genetic risk of developing cancer .	✗ No
If you're an in-patient or day-patient	
Specialist fees for the specialist treating your cancer when you are an in-patient or day-patient .	✓ Yes
Diagnostic tests as an in-patient or day-patient .	✓ Yes

If you're an out-patient	
Specialist consultations with the specialist treating your cancer when you are an out-patient .	✓ Yes
Diagnostic tests as an out-patient when ordered or performed by the specialist treating your cancer .	✓ Yes
Surgery	Am I covered?
Whether you are an in-patient , day-patient or out-patient	
Surgery for the treatment or diagnosis of cancer , so long as it is conventional treatment . » See section 7 for how we define surgery. » See 3.3 for more about conventional and unproven treatment.	✓ Yes
Reconstructive surgery following breast cancer	Am I covered?
The first reconstructive surgery following surgery for breast cancer . We will cover: <ul style="list-style-type: none"> ▪ one planned surgery to reconstruct the diseased breast ▪ nipple tattooing, up to 2 sessions ▪ one planned surgery to reconstruct the nipple. 	✓ Yes We will do this so long as: <ul style="list-style-type: none"> ▪ you had continuous cover under a private medical insurance plan since before the surgery happened; and ▪ we agree the method and cost of the treatment in writing beforehand.

After the completion of your first reconstructive **surgery**, we will also cover:

- one further planned **surgery** to the other breast, when it has not been operated on, to improve symmetry.
- two planned fat transfer **surgeries** to the diseased breast. The fat must be taken from another part of your body and cannot be donated by anyone else.
- one further planned **surgery** due to the medical failure of your first reconstruction.
- one planned **surgery** to remove and exchange implants damaged by radiotherapy **treatment** for breast **cancer**.

If you choose not to have reconstructive **surgery** following **treatment** of **breast cancer**, we will cover the cost of one planned **surgery** to the unaffected breast to improve **symmetry**.

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

✓ Yes

Symmetry and fat transfer operations must take place within three years of your first reconstructive **surgery**.

Surgery due to failure of your breast reconstruction must take place within three years of your first reconstruction **surgery**. This must be agreed with us before you have **surgery**.

The removal and exchange of radiotherapy damaged implants must take place within five years of you completing your radiotherapy **treatment**.

We will only pay for each of these operations once (or two fat transfer **surgeries**), regardless of how long you remain a member of AXA PPP healthcare.

✓ Yes

No further reconstructive surgery will be covered on either the diseased breast or the unaffected breast.

✗ No

» See also 4.7 > **Cosmetic treatment, surgery or products**

Preventative	Am I covered?
<p>Preventative treatment, such as:</p> <p>Screening when you do not have symptoms of cancer. For example, if you had a screen to see if you have a genetic risk of breast cancer, we would not cover the screening or any treatment to reduce the chances of developing breast cancer in future (such as a preventative mastectomy).</p> <p>Vaccines to prevent cancer developing or coming back – such as vaccinations to prevent cervical cancer.</p>	<p>✘ No</p>
Drug therapy	Am I covered?
<p>Out-patient drugs or other drugs that a GP could prescribe or could be bought over the counter. This includes drugs or prescriptions you are given to take home if you have had in-patient, day-patient or out-patient treatment.</p>	<p>Please call us about these drugs. We don't cover them, but we can help you apply to get these paid for by the NHS. Call us on 0800 068 7111 and we can talk you through this.</p>
<p>Drug treatment to kill cancer cells – including:</p> <ul style="list-style-type: none"> ▪ biological therapies ▪ chemotherapy. 	<p>✔ Yes</p> <p>There is no time limit on how long we cover these drugs.</p> <p>We will cover them if:</p> <ul style="list-style-type: none"> ▪ they have been licenced by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency, and ▪ they are used according to their licence, and ▪ they have been shown to be effective. <p>Because drug licences change, this means that the drugs we cover will change from time to time.</p> <p>Please call once you know your treatment plan.</p>

Unproven drugs	<p>✗ No</p> <p>There is no cover for unproven drugs or drugs that are being used outside of their licence.</p> <p>» Please see section 3.3 for more information on unproven treatment.</p>
Advanced therapy medicinal products (ATMPs)	<p>✓ Yes</p> <p>We cover a small number of approved ATMPs. Please see axahealth.co.uk/atmps for the list of ATMPs that we cover, or call us.</p> <p>» Please see section 4.2 for more information on ATMPs</p>
<p>Other drugs. We cover:</p> <ul style="list-style-type: none"> ▪ Hormone therapy that is given by injection (for example goserelin, also known as Zoladex) ▪ Antivirals, antibiotics, antifungals, anti-sickness and anticoagulant drugs 	<p>✓ Yes</p> <p>They are covered as long as you have them at the same time as you are having chemotherapy or biological therapy to kill cancer cells covered by your membership.</p>
<p>We will also cover bone strengthening drugs such as bisphosphonates or Denosumab that are:</p> <ul style="list-style-type: none"> ▪ licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and used according to that license; or ▪ being used as recommended by the National Institute for Health and Care Excellence (NICE) as a treatment that may be used in routine practice. 	<p>✓ Yes</p> <p>We will only pay for these drugs when they can't be prescribed by a GP.</p>
Drugs for treating conditions secondary to cancer , such as erythropoietin (EPO).	<p>✓ Yes, while you are having chemotherapy that is covered by your membership.</p>
Radiotherapy	Am I covered?
Radiotherapy including when it is used to relieve pain.	<p>✓ Yes</p>

<p>Proton Beam Therapy (PBT)</p>	<p>✓ Yes</p> <p>We will pay for PBT for cancer when it is in line with treatment that is routinely commissioned by the NHS.</p> <p>We will not pay for PBT in any other circumstances.</p> <p>As PBT is a developing area of medicine there are only a limited number of facilities that provide this treatment. Please contact us before you have your treatment.</p>
<p>Accelerated charged particle therapies</p>	<p>✗ No</p> <p>However, there is limited cover for proton beam therapy in the circumstances shown above.</p>
<p>Palliative and end of life care</p>	
<p>Care to relieve pain or other symptoms rather than cure the cancer.</p>	<p>Am I covered?</p> <p>✓ We will provide cover and support throughout your cancer treatment even if it becomes incurable. We cover radiotherapy, chemotherapy and surgery (such as draining fluid or inserting a stent) to relieve pain.</p>
<p>Donation to a hospice where you are having end of life care, or a donation to a service providing hospice at home.</p>	<p>✓ £75 for each night. This is a charitable donation paid direct to a registered hospice charity when you are provided free treatment in a hospice.</p>
<p>Donation to a registered hospice charity that is providing you with end of life care, either at a hospice or for hospice at home care.</p>	<p>✓ £75 for each day. This is a charitable donation paid direct to a registered hospice charity when you are provided free hospice at home care treatment instead of having treatment in a hospice.</p>
<p>Monitoring</p>	
<p>Follow ups – cover for follow up consultations and reviews for cancer.</p>	<p>Am I covered?</p> <p>✓ Yes, so long as you are still a member and have a plan that covers this.</p>

<p>Routine monitoring or checks that a GP or someone else in a GP surgery (or other primary care setting) could carry out.</p>	<p>✗ No</p>
<p>Follow up procedures that are for monitoring rather than treatment. Some cancer patients need procedures to check whether cancer is still present or has returned. For example, these could include colonoscopies to check the bowel or cystoscopies to check the bladder.</p>	<p>✓ Yes</p>
<p>Limits</p>	<p>Am I covered?</p>
<p>Time limits on cancer treatment. Your membership covers you while you are having treatment to kill cancer cells.</p>	<p>None</p>
<p>Money limits on cancer treatment</p>	<p>No specific limits – same rules apply to your cancer treatment as for any other treatment.</p>
<p>Other benefits</p>	<p>Am I covered?</p>
<p>Stem cell or bone marrow transplant.</p>	<p>✓ Yes</p> <p>We will cover the reasonable costs for a stem cell or bone marrow transplant as long as:</p> <ul style="list-style-type: none"> ▪ the stem cell or bone marrow transplant is for the treatment of cancer; and ▪ it is conventional treatment for that cancer. <p>It does not include any related administration costs. For example, we will not cover the cost of searching for a donor, the harvesting of cells from the donor or transport costs for tissue or harvested cells.</p> <p>» Please see section 3.3 for more information on conventional treatment</p> <p>» Please see section 4.22 for more information on Organ or tissue transplant</p>

The cost of wigs or other temporary head coverings or external prostheses needed because of **cancer** whilst you are having **treatment** to kill **cancer** cells.

✓ Up to £400 a **year** for wigs or head coverings and up to £5,000 a **year** for prostheses.

4.1b > Cancer cover - NHS Cancer Support

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

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

We will pay if:

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

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

4.2 > Advanced therapy medicinal products (ATMPs)

Advanced therapy medicinal products (ATMPs) are a complex set of medications defined by the Medicines and Healthcare products Regulatory Authority. ATMPs include things like gene therapies and CAR-T **treatment** for **cancer**.

We only cover a small number of approved ATMPs under the **plan**. You must call us before you start your **treatment** to make sure it's covered.

For more information and for the current list of the ATMPs we cover please visit www.axahealth.co.uk/atmps or call us.

We don't cover any ATMPs that aren't on the list at the time you need the **treatment**, including any associated hospital or **specialist** costs. The list is subject to change so you should always check and call us before you start any **treatment**.

4.3 > Alcohol abuse, drug abuse, substance abuse

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

4.4 > Breast reduction

We do not cover either male or female breast reduction.

4.5 > Chiropody and foot care

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

4.6 > Contraception

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

4.7 > Cosmetic treatment, surgery or products

We do not cover:

- Cosmetic **treatment** or cosmetic **surgery**; or
- **treatment** that is connected to previous cosmetic **treatment** or cosmetic **surgery**; or
- **treatment** that is connected with the use of cosmetic (beauty) products or is needed as a result of using a cosmetic (beauty) product.

» See also 4.25 > Reconstructive surgery

4.8 > Criminal activity

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

4.9 > Drugs and dressings

We do not cover drugs, dressings or prescriptions that:

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

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

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

4.10 > Dialysis

We do not cover regular or long term dialysis if you have chronic organ failure.

» Please see section 3.5 > How your membership works with conditions that last a long time or come back (chronic conditions) to understand your cover.

4.11 > External prosthesis or appliances

What is covered?

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

We will do this so long as:

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

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

What is not covered?

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

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

How to claim

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

4.12 > Eye conditions

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

- refractive errors (this includes long or short sightedness and astigmatism).
- eye co-ordination (convergence insufficiency).
- eye focusing problems (accommodative dysfunctions).

4.13 > Fat removal

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

4.14 > Gender reassignment or gender confirmation

We do not cover gender re-assignment or gender confirmation or any connected **treatments**.

4.15 > Genetic tests

What is covered for genetic tests?

- We will pay for genetic testing when it is proven to help choose the best **eligible treatment** for your **medical condition**.

» See section 3.3 regarding how we define **eligible treatment**, **conventional treatment** and **unproven treatment**.

We do not cover genetic tests:

- to check whether you have a **medical condition** when you have no symptoms or you have a genetic risk of developing a **medical condition** in the future; or
- to find out if there is a genetic risk of you passing on a **medical condition**; or

- where the result of the test wouldn't change the course of **eligible treatment**. This might be because the course of **eligible treatment** for your symptoms will be the same regardless of the result of the test or what **medical condition** has caused them; or
- that themselves are not **conventional treatment** or where they are used to direct **treatment** that is not **eligible treatment**.

In addition, genetic tests must be:

- Listed in the NHS England National genomic test directory and used for the purposes listed in the directory; and
- Carried out at a testing laboratory which is accredited by the United Kingdom Accreditation Service (UKAS) or an equivalent agreed in advance of testing by AXA Health.

» See Section 4.24 > Preventative treatment and screening tests .

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

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

4.16 > GP and primary care services

Your cover includes access to the AXA Doctor at Hand service for video and telephone consultations as shown in the benefits table. We do not cover any other primary care services or **treatment** that would normally be carried out in a primary care setting such as the routine management of a **medical condition**. This includes any fees for services that a GP, dentist or optician could normally carry out, or any other primary care services.

There is extra cover for GP and other primary care services if you have the 'Plus' optional upgrade.

✓ Extra cover if you have the 'Plus' optional upgrade

If you have the Plus upgrade, you have cover for private GP consultations and GP minor surgery as shown in the benefits table

4.17 > Infertility and assisted reproduction

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

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

4.18 > Learning and developmental disorders

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

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

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

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

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

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

4.20 > Mental health

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

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

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

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

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

What if my condition goes on for a long time?

Our normal rules on **chronic conditions** apply to mental health problems. So if your condition becomes chronic, unfortunately we may no longer be able to cover your

treatment. If this happens, we will contact you beforehand so that you can decide whether to start paying for the **treatment** yourself, or to transfer to the NHS.

» For more details, see 3.5

What is not covered?

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

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

4.21 > Nuclear, biological or chemical contamination and war risks

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

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

4.22 > Organ or tissue transplant

Plan 1, Plan 2, Plan 3

What is covered for organ or tissue transplant?

We will pay for:

- Stem cell or bone marrow transplant when:
 - **treatment** is for the **treatment of cancer**; and
 - it is **conventional treatment** for that **cancer**.
- **surgery** using donated stored tissue, where it is integral to the **surgical procedure**, for example ligament reconstruction, replacement heart valve or corneal transplant.

» See also 4.1a > Comprehensive cancer cover

Plan 1, Plan 2, Plan 3, Plan 4

What is not covered for organ or tissue transplant?

We do not pay for:

- any **surgery** or **treatment** required to receive an organ for example, the receiving of a heart or lung; or
- any **surgery** or **treatment** required to donate an organ for example, the giving of a kidney; or
- any **treatment** needed in preparation for a transplant, or as a result of a transplant, for example dialysis; or
- the cost of collecting donor organs, tissue, or harvesting cells from a donor; or

- any related administration costs – for example, the cost of searching for a donor or transport costs for tissue or harvested cells.

4.23 > Pregnancy and childbirth

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

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

What is covered?

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

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

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

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

4.24 > Preventative treatment and screening tests

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

What is not covered for preventative treatment and screening tests?

We do not pay for:

- preventative **treatment**, such as preventative mastectomy or a YAG laser iridotomy for narrow angles in isolation; or
- preventative screening tests; or
- routine preventative examinations and check-ups; or
- tests to check whether:
 - you have a **medical condition** when you have no symptoms; or
 - you have a risk of developing a **medical condition** in the future; or
 - there is a risk of you passing on a **medical condition**.

- tests where the result of the test wouldn't change the course of **eligible treatment**. This might be because the course of **eligible treatment** for your symptoms will be the same regardless of the result of the test or what **medical condition** has caused them; or
- preventative **treatment** or screening tests that themselves are not **conventional treatment** or where they are used to direct **treatment** that is not **eligible treatment**; or
- any other preventative screening or **treatment** to see if you have a **medical condition** if you do not have symptoms; or
- vaccinations.

» See also section 4.15 > Genetic tests

4.25 > Reconstructive surgery

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

What is covered?

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

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

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

What is not covered?

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

» See also 4.1 > Cancer for details of the cover for breast reconstruction and 4.7 > Cosmetic treatment, surgery or products

4.26 > Rehabilitation

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

What is covered for rehabilitation?

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

- it follows an acute brain injury, such as a stroke; and
- it is part of **treatment** of an **acute condition** that is covered by your membership; and
- a **specialist** in rehabilitation is overseeing your **treatment**; and
- you have your **treatment** in a rehabilitation hospital or unit that is included in our **Directory of Hospitals** or which we have written to confirming it's recognised by us; and

- the **treatment** can't be carried out as a **day-patient** or **out-patient**, or in another suitable location; and
- we have agreed the costs before you start rehabilitation.

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

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

4.27 > Self-inflicted injury and suicide

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

4.28 > Sexual dysfunction

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

4.29 > Social, domestic and other costs unrelated to treatment

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

4.30 > Sports related treatment

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

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

4.31 > Sterilisation

We do not cover:

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

4.32 > Teeth and dental conditions

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

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

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

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

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

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

4.34 > Treatments not covered by the plan

We don't cover **treatment** that is connected to anything not covered under the **plan**. This means we won't pay for further **treatment** or increased **treatment** costs if you have any medical or **surgical procedure** we wouldn't have covered under the **plan**. We also won't pay if you need **treatment** as a result of a body modification.

There is no cover for any costs for investigations, tests or **treatments** which are only needed so you can have **treatment** that isn't covered under the **plan**. It also includes costs if you are planning to have a medical or **surgical procedure** or body modification that wouldn't be covered under the **plan**.

4.35 > Treatment that is not medically necessary

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

4.36 > Varicose veins

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

What is covered?

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

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

What's not covered?

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

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

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

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

4.37 > Warts

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

4.38 > Weight loss treatment

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

What is not covered?

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

5 Managing your membership

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

5.1 > Adding a family member or baby

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

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

Who you can add

You can normally add:

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

If you would like to add a new baby to your cover, you can normally do this from their date of birth, so long as you let us know within 13 weeks of their birth.

We normally will not need details of their medical history.

If your agreement with your **group** allows you to add a baby after they are 13 weeks old, we may ask for details of their medical history. The information we will ask for will depend on the agreement we have with the **group** regarding **pre-existing conditions**.

»For more information see section 3.4 > How your membership works with pre-existing conditions and symptoms of them.

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

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

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

- We will not cover any **treatment** in a Special Care Baby Unit or paediatric intensive care.
- We may ask for more details or the baby's medical history or add other conditions to the baby's cover, unless your **group** have joined on a medical history disregarded basis. For example, we may limit their cover for **pre-existing conditions**.

» For more information see section 3.4 > How your membership works with pre-existing conditions and symptoms of them.

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

5.2 > Paying your excess

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

If you have an excess

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

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

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

Claims that you do not have to pay an excess for

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

- NHS radiotherapy and chemotherapy cash benefit.
- NHS cash benefit.
- Hotel accommodation benefit.
- **External prostheses.**
- Childbirth benefit
- Any claim for wigs, head coverings, other temporary head coverings in relation to **treatment of cancer** or hospice donations.
- Consultations with the AXA Doctor at Hand service.

5.3 > Keeping us informed

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

Changes you must tell us about

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

5.4 > If you move abroad

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

5.5 > Paying income tax on your subscription

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

5.6 > Cancelling your membership

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

5.7 > Leaving your group

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

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

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

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

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

We'll arrange everything over the phone.

5.8 > Making a complaint

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

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

Making a complaint

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

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

Please call us on 01923 770 000.

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

Or email: support@thephc.co.uk

Answering your complaint

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

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

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

The Financial Ombudsman Service

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

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

The Financial Ombudsman Service
Exchange Tower, Harbour Exchange Square

London E14 9SR

Phone: 0300 123 9 123 or 0800 023 4567

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

Website: financial-ombudsman.org.uk

Your legal rights

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

6 Legal information

- 6.1 > Rights and responsibilities
- 6.2 > Our authorisation and regulation details
- 6.3 > The Financial Services Compensation Scheme (FSCS)
- 6.4 > Your personal information
- 6.5 > What to do if somebody else is responsible for part of the cost of your claim
- 6.6 > What to do if your claim relates to an injury or medical condition that was caused by another person

6.1 > Rights and responsibilities

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

The plan

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

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

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

All cover ends when the **group** membership ends. If the **lead member** leaves the **group**, cover for the **lead member** and their **family members** ends.

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

We will pay for covered costs under the terms of this **plan** when **treatment** takes place in a period for which the **premium** has been paid.

We will not pay any costs for **treatment** or services received after the end of your period of cover under the **plan**, even if we had already pre-authorised it. Your **treatment** is provided through a separate agreement between you and your **treatment** provider. The date(s) you receive your **treatment** is part of that agreement.

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

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

Your Certificate of Cover is proof of your cover.

Renewal

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

Providing us with information

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

You must let the **group** administrator know if you change your address.

Our right to refuse to add a family member

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

Subrogated rights

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

For example, we may recover amounts from someone who caused injury or illness, or from another insurer or a state healthcare provider. We may use external legal, or other, advisers to help us do this.

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

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

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

What happens if you break the terms of the plan

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

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

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

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

International Sanctions

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

What happens if the group insurance contract ends

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

Legal rights

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

Law applying to the plan

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

Language for the plan

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

6.2 > Our authorisation and regulation details

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

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

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

You can check details of our registration on the FCA website: [fca.org.uk](https://www.fca.org.uk)

6.3 > The Financial Services Compensation Scheme (FSCS)

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

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

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

You can find more information about the scheme on the FSCS website: [fscs.org.uk](https://www.fscs.org.uk).

6.4 > Your personal information

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

Please make sure that everyone covered by this **plan** reads this summary and the full data privacy notice on our website. If you would like a copy of the full notice call us on 0800 068 7111 and we'll send you one.

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

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

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

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

- manage your claims, e.g. to deal with your doctors or any reinsurers;
- manage the **plan** with your insurance broker
- help us prevent and detect crime and medical malpractice by talking to other insurers and relevant agencies; and

- allow other AXA companies in the **UK** to contact you if you have agreed.

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

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

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

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

You must tell us if you are able to recover any part of your claim from any other party.

Other parties would include:

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

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

You must tell us as quickly as possible if you believe something or someone else contributed to or caused the need for your **treatment**. For example, if you were injured in a road traffic accident that wasn't your fault or potential clinical negligence.

This does not change the benefits you can claim under the **plan** (your "Claim"). It also means that you can potentially be repaid for any costs you paid yourself, such as your excess or if you paid for private **treatment** that wasn't covered by the **plan**. Where appropriate, we will pay our share of the Claim and recover what we pay from the person or organisation responsible. We may use external legal, or other, advisers to help us do this.

If you decide to take legal action, there are some rules you need to follow and you need to keep us up to date with the case.

The amount you claim through your legal action needs to include the whole amount we have paid for **treatment**, plus 8% interest per year.

The amount we paid for your **treatment** is our 'Outlay' against the person or organisation you're pressing action against. We need to agree if you are claiming less than our Outlay. If we don't and your payment is less than our Outlay, we may ask you to pay the rest of it, plus interest.

You must pay us our Outlay and interest within 21 days of the settlement date. You also need to provide us full details of the settlement.

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

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

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

7 Glossary

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

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

acupuncturist – a medical practitioner who specialises in acupuncture who is registered under the relevant Act or a practitioner of acupuncture who is registered as a member of the British Acupuncture Council (BacC). In all cases, the acupuncturist needs to meet our criteria for recognition. We must have told them in writing that we currently recognise them as an acupuncturist to provide **out-patient treatment** only.

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

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

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

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

chiropractor – a medical practitioner who practices chiropractic **treatment** 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 chiropractor 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.

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

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

conventional treatment – **treatment** that is established as best medical practice, and is practised widely in the **UK**. It must also be clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the **treatment** is provided. In addition, to meet our definition, it must be approved by NICE (The National Institute for Health and Care Excellence) as a **treatment** which may be used in routine

practice. Otherwise, it must have high quality clinical trial evidence proving it is effective and safe for the **treatment** of your **medical condition** (full criteria available on request). If the **treatment** is a drug, the drug must be:

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

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

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

» The units we recognise are listed in our **Directory of Hospitals**. Please call PHC for the latest list.

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

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

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

» The facilities we recognise are listed in your **Directory of Hospitals**. Please call PHC for the latest list.

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

eligible treatment - is **treatment** of a **medical condition** that is covered by this **plan** and is not excluded by any of the rules in this handbook. You should read all sections of this handbook together.

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

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

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

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

fee-approved specialist – a **specialist** whose fees for covered **treatment** we routinely pay in full.

fee-limited specialist – a **specialist** whose fees for covered **treatment** we pay up to the amount shown in the schedule of procedures and fees.

» The schedule of procedures and fees is on our website: <https://www.thephc.co.uk/phc-members-area/how-to-claim>

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

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

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

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

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

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

osteopath – a medical practitioner who practices osteopathy 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 an osteopath 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.

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

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

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

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

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

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

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

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

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

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

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

» The centres we recognise are listed in the **PHC Directory of Hospitals**

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

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

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

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

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

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

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

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

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

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

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

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

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

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



The Permanent Health Company Limited

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Write to us at: PHC, 32 Church Street, Rickmansworth, Hertfordshire, WD3 1DJ.

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

Company HealthCover4life Handbook April 2024