health-on-line

Health For You Handbook
Details of your Health For You insurance policy

April 2021

Welcome

Thank you for choosing Health For You from Health-on-Line.

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

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

If anything is not clear, please call us.

Questions about your policy

0800 533 5921

Monday to Friday 8am to 6pm

Claims

0345 600 1292

Monday to Friday 8am to 6pm

24 hour medical help and information

0800 003 004

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

Manage your membership online

You can make a claim or pre-authorise treatment at www.health-on-line.co.uk/my-account-login
You can also view your membership documents, update your personal details, message us and manage your membership securely.

We are committed to giving customers access to our products. To contact us by Next Generation Text on any of the numbers listed in this handbook just prefix the number listed with 18001. For example, our team of Personal Advisers can be contacted by Next Generation Text on 18001 0345 600 1292. For Health queries and information 18001 0800 003 004.

Contents

1 Quick-start guide to your cover

This section explains the basics of your cover. 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.

This policy meets the demands and needs of someone seeking the cover set out in following sections 1.1, 1.2, 1.3, 1.4 and 1.5 and should be read alongside your personalised policy guide which shows which cover options you have purchased.

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 **policyholder** and any **family members** covered by your **policy**.

We, us and our

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

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

If you have **treatment** at a hospital or **day-patient unit** that's not in the **hospital list**, we will only pay 60% of the charges from that hospital or **day-patient unit** as long as they charge up to the normal rates published and charged by that hospital or **day-patient unit**. You will be responsible for paying the remaining charges.

1.2 > Why it's important to use Health For You specialists

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

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

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

We strongly recommend that you call us on 0345 600 1292 before you arrange a consultation or treatment so that we can check that you're covered.

1.3 > Your core cover – applies to all

This table shows you the core cover your policy gives you.

Core cover table		
If you're an **in-patient** or **day-patient**		
Private hospital and **day-patient unit** fees	✓ Paid in full so long as you use a **private hospital** or **day-patient unit** listed in the **hospital list**	Including fees for **in-patient** or **day-patient**: • accommodation • **diagnostic tests** • using the operating theatre • nursing care • drugs • dressings • physiotherapy • surgical appliances that the **specialist** uses during **surgery**. » **For details, see 3.8**
Specialist fees	✓ No yearly limit so long as you use a **Health For You specialist**	Includes fees for: • surgeons • anaesthetists • physicians. » **For details, see 3.6**
Hospital 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 **policy** and be 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 be having **treatment** covered by the **policy** 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. Also, it will not affect any no claims discount you have.
If you're an **out-patient**		
Surgery	✓ No yearly limit	» **For details, see 3.8**
Other cover		
AXA Doctor at Hand	✓ Unlimited video or telephone consultations through the AXA Doctor at Hand service, an online, private **GP**.	Access to the AXA Doctor at Hand service, a private **GP** for video or telephone consultations. For information on terms and conditions, registering and how to use this service, please visit: member.doctorcareanywhere.com/SignUp/axa If you have an excess, we will not take this off this benefit. Also, it will not affect any no claims discount you have. This benefit is not available on policies where only a child under 18 has cover.
Ambulance transport	✓ Paid in full	If you are having private **in-patient** or **day-patient treatment** and it is medically necessary to use a road ambulance to transport you to another medical facility.
Health at Hand	✓ Direct access to healthcare experts 24/7	» **For details, see 1.6**

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

Nurse to give you antibiotics by intravenous drip at home	✓ Paid in full	We will pay for **treatment:** • at home or • somewhere else that is appropriate. We will pay for a nurse to give antibiotics by intravenous drip: This is so long as: • we have agreed the **treatment** beforehand; and • you would otherwise need to be admitted for **in-patient** or **day-patient treatment**; and • the **nurse** is working under the supervision of a **specialist**; and • the **treatment** is provided through a healthcare services supplier that we have a contract with for this kind of service.
Cash payment when you have free **in-patient treatment** under the NHS	✓ £50 a night up to £2,000 a **year**	We pay this when: • you are admitted for **in-patient treatment** before midnight; and • we would have covered your **treatment** if you had had it privately. 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. Also, it will not affect any no claims discount you have.
External prosthesis	✓ Up to £5,000 for the lifetime of your membership	We will pay this benefit towards the cost of providing an **external prosthesis**. If you have an excess, we will not take this off this cash payment. Also, it will not affect any no claims discount you have. » **For details, see 4.11**
Oral surgery	✓ Paid in full in a private hospital or day-patient unit in the **hospital list**	So long as your dentist refers you, we will pay for: • reinserting your own teeth after a trauma; or • surgical removal of impacted teeth, buried teeth and complicated buried roots; or • removal of cysts of the jaw (sometimes called enucleation). » **To check if we have an agreement with a facility for oral surgery, see the hospital list at axappphealthcare.co.uk/hospitals** » **For details, see 4.35**

Cancer cover

There are two levels of **cancer** cover with Health For You. They are Comprehensive Cancer Cover and NHS Cancer Support. For details of both see section 4.1 of this handbook. Your policy statement, which is part of your **policy** guide, will tell you which level of cancer cover you have.

1.4 > Extra cover from Options

The following tables show you what cover your Options give you. You may have chosen to add some of these when you took out your **policy**. Your **policy** guide shows which Options you have chosen.

Out-patient Options

Standard Out-patient Option table

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

Specialist consultations	✓ Up to three **specialist** consultations a **year**	We pay for consultations in the order we assess the claims, which may not be the same order that you had the consultations. So the consultations we pay for may not be the first three that you had. » **For details, see 3.7**

Practitioner fees when your **specialist** refers you **Diagnostic tests** performed at an authorised facility when a **GP** at the AXA Doctor at Hand service refers you **Diagnostic tests** performed by your **specialist or** when your **specialist** refers you	✓ No yearly limit	**Practitioners** are **nurses**, dieticians, orthoptists, speech therapists and audiologists. Claiming for speech therapist's fees will not affect your no claims discount. Diagnostic tests when a **GP** at the AXA Doctor at Hand service refers you are only available to members over 18.
CT, MRI or PET scans	✓ Paid in full at a **scanning centre**, or hospital listed as a **scanning centre** in the **hospital list**	A **specialist** must refer you. CT = Computerised Tomography MRI = Magnetic Resonance Imaging PET = Positron Emission Tomography

Full Out-patient Option table

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

Specialist consultations **Diagnostic tests** when performed by your **specialist** or when your **specialist** refers you **Diagnostic tests** performed at an authorised facility when a **GP** at the AXA Doctor at Hand service refers you **Practitioner** fees when your **specialist** refers you	✓ No yearly limit	**Practitioners** are **nurses**, dieticians, orthoptists, speech therapists and audiologists. Claiming for speech therapist's fees will not affect your no claims discount. » **For details, see 3.7** Diagnostic tests when a **GP** at the AXA Doctor at Hand service refers you are only available to members over 18.
CT, MRI or PET scans	✓ Paid in full at a **scanning centre**, or hospital listed as a **scanning centre** in the **hospital list**	A **specialist** must refer you. CT = Computerised Tomography MRI = Magnetic Resonance Imaging PET = Positron Emission Tomography

Therapies Option table

Fees for **out-patient treatment** by **physiotherapists**, **acupuncturists**, **homeopaths**, **osteopaths** or **chiropractors**	✓ A combined limit of £500 a **year** that can include: • Up to an overall maximum of ten sessions in a year when your **GP** refers you or when you have physiotherapist **treatment** through our Working Body team. • Further sessions (as long as we agree them first) when your **specialist** refers you.	Claiming for this will not affect your no claims discount. » **For details, see 3.7**

Mental Health Option table

If you're an **in-patient** or **day-patient**

Private hospital and **day-patient unit** fees for psychiatric **treatment**	✓ Paid in full for up to 30 days a **year**	So long as you use a hospital or **day-patient unit** in the **hospital list**. Including fees for: • accommodation • **diagnostic tests** • drugs. » **For details, see 3.8**
Specialist fees for psychiatric **treatment**	✓ No yearly limit so long as you use a **Health For You specialist**	» **For details, see 3.7**

If you're an **out-patient**

Specialist consultations for psychiatric **treatment**	✓ A combined limit of £1,000 a **year**	» **For details, see 3.7**
Psychiatric **treatment** by **psychologists** and **cognitive behavioural therapists**		

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.

Dentist and Optician Cashback Option table		
Dentist fees	✓ 80% of your dentist's fees, up to £400 a **year**	This benefit is not subject to the restrictions for pre-existing conditions described in section 3.4. If you have an excess, you do not have to pay the excess if you claim for dentist fees. Claiming for dental fees will not affect your no claims discount. » **For details, see 4.35**
Optician fees	✓ 80% of the cost of prescribed glasses and contact lenses, up to £200 a **year**	This benefit is not subject to the restrictions for pre-existing conditions described in section 3.4. We will pay this so long as the glasses or lenses are used to correct your vision. If you have an excess, you do not have to pay the excess if you claim for optician fees. Claiming for optician fees will not affect your no claims discount. » **For details, see 4.19**
Eye test	✓ Up to £25 a **year** for an eye test	This benefit is not subject to the restrictions for pre-existing conditions described in section 3.4. If you have an excess, you do not have to pay the excess if you claim for an eye test. Claiming for an eye test will not affect your no claims discount. » **For details, see 4.19**

Private GP Cover Option table		
Fees for visits to a private **GP** for consultations	✓ Up to £500 a **year**	Claiming for **GP** fees will not affect your no claims discount.

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.

Travel Cover Option table		
There are two levels of travel cover available with Health For You.		Available as a separate AXA PPP healthcare policy. » **For details see your European and Worldwide Travel Cover handbook.**

1.5 > The main things we don't cover

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

Does my policy 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 policy doesn't cover?

Your policy does not cover	For more information	Notes
× **Treatment** of **medical conditions** you had, or had symptoms of, before you joined.	» **For details, see 3.4**	Your **policy** 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**	
× **Treatment** of **cancer** except as shown in 4.1b, if you do not have Comprehensive Cancer Cover.	» **For details, see 4.1**	
× Pregnancy and childbirth	» **For details, see 4.24**	Few health insurance policies cover pregnancy and childbirth because they are not illnesses, and the NHS is set up to deal with them.

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

When you took out your **policy**, you chose whether to extend it with Options. Some of your cover depends on which Options you chose.

Your policy statement, which is part of your policy guide, shows you which Options you have.

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

☎ If you have any questions about your cover please call us on 0345 600 1292.

If you would like to add cover to your policy, you can usually do this:
- **within 14 days of receiving your documents, or**
- **when you renew.**

Just call us on 0800 533 5921 and we'll be happy to help.

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

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

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

Call 0800 003 004

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

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

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

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.

2 Making a claim

1 Ask your GP for an open referral

If your GP says you need specialist treatment, tell them you want to go private and ask for an 'open referral'.

With an open referral your GP doesn't name a particular specialist, but instead gives you the type of specialist you need to see, for example a cardiologist. This means our Fast Track Appointments service can help you find a suitable specialist and make a convenient appointment for you.

Occasionally the NHS will be best placed to provide care locally (for example specialist paediatric (children's) care at an NHS centre of excellence). When this is the case we will talk to you about your NHS options as well.

2 Contact us on 0345 600 1292 or through your online account 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. You can pre-authorise treatment by phone or online, but if your claim is urgent we recommend you call us so we can make sure you are covered for your claim before you have any treatment.

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

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

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

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

The AXA Doctor at Hand service offers you cover for video or phone consultations, wherever you may be in the world.

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

Register for the AXA Doctor at Hand service

For everything you need to know about the service, including how to register and full terms and conditions, please visit: member.doctorcareanywhere.com/SignUp/axa

Using the AXA Doctor at Hand service

After you've registered, you can book an appointment online at doctorcareanywhere.com or use the

Doctor Care Anywhere app, available to download from the App Store or Google Play.

Your condition and treatment

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 your policy.

If the doctor says you need **treatment**, you must call us to check that the treatment is covered.

The AXA Doctor at Hand service cannot refer you to the NHS for specialist treatment directly. If you want to have NHS treatment, please contact your NHS GP.

Private prescriptions and delivery

If the GP at 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 your policy.

Out-patient diagnostic tests – available if you have an out-patient Option

If the **GP** at the AXA Doctor at Hand service thinks you need **diagnostic tests**, there are certain tests for some **medical conditions** they can refer you for,

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.

before you see a **specialist.** The **GP** will contact us to check your cover before you are referred to an authorised facility for your **diagnostic tests**. The **GP** at the AXA Doctor at Hand service will take you through the results and discuss any **treatment** options with you.

You must call us to check that any further **treatment** is covered.

You can only be referred for **diagnostic tests** by a **GP** at the AXA Doctor at Hand service if you are over 18. If you are under 18 all **diagnostic tests** will need to be under **specialist** referral.

About the AXA Doctor at Hand service terms

The AXA Doctor at Hand service is provided by Doctor Care Anywhere.

By using the service, you agree to Doctor Care Anywhere's terms and conditions. You will be asked to review and confirm you agree to these when you register.

Appointments can be rearranged but not cancelled with less than 12 hours' notice.

For muscle, bone and joint pain, you can use Working Body – no GP referral needed

When you experience muscle, bone or joint pain, it's important that you get the most appropriate support early. That's why, with 'Working Body', we've made it easy for you to speak to our team of experts.

With 'Working Body' you can get access to advice and treatment without the need for a GP referral. As soon as you develop a problem, just call your Personal Advisory team. We'll check what cover you have and you'll get a call back by the end of the next working day to arrange a free telephone assessment.

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

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

For skin or breast concerns you can use our self-referral service

If you are concerned about any marks or moles on your skin, or symptoms or changes in your breast(s), you can call your Personal Advisers to see whether the self-referral service can help. You can choose to use the service without seeing your GP first.

Call us on 0345 600 1292 - You can call your Personal Advisers as soon as you experience problems or have any concerns. They will check your cover and take you through some questions designed to show whether the service can help.

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

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

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

How we pay claims

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

How we pay medical bills?

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

For more details about paying your excess, see 5.4

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 from the **specialist** or hospital to Health on Line Claims Department, PO Box 503, Tunbridge Wells, TN2 9RT.

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 contact us and we'll explain what to do next.

What should I do if I need further treatment?

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

The information we may need when you make a claim

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

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

What does 'more detailed information' mean?

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

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

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

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

What if my treatment isn't covered?

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

What if I want to see a specific specialist?

We always recommend that you ask your **GP** for an open referral. That's a referral that does not name a specialist. With an open referral, you'll be able to use one of our **Health For You specialists** knowing that we'll pay for **treatment** you're covered for.

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

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

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

What happens if I need emergency treatment?

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

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

You may be able to claim a cash payment for each night you spend in an NHS hospital if you are having **in-patient treatment** which would have been covered under your **policy**.

» For more details, see the Core Cover table

3 How your policy works

How your policy works

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

Any questions?

If you're unsure how something works, just call us on 0800 533 5921 and we'll be very glad to explain. It's often quicker and easier than working it out from the handbook alone.

Making a claim

If you would like to make a claim, please call us on 0345 600 1292 or go to your online account first and we'll be able to check your cover for you and tell you what to do next.

3.1 > Looking at who should provide treatment

Your membership provides access to the AXA Doctor at Hand service for video or phone **GP** consultations. When **diagnostic tests** are routinely required as part of your referral to a **specialist**, a **GP** at the AXA Doctor at Hand service may arrange these for you. The results of your **diagnostic tests** will be reviewed and the **GP** at the AXA Doctor at Hand service will discuss any **treatment** options with you. This will ensure you see the right type of **specialist** for your **medical condition** and to help the **specialist** to quickly and effectively diagnose or identify what **treatment** may be required

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

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

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

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

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

If you have the Private GP Cover Option you have some cover for private **GP** consultations.

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

3.2 > Eligible treatment

Your membership covers 'eligible **treatment**'. You will need to read all sections of this handbook to understand whether **treatment** is eligible **treatment**.

'Eligible **treatment**' is **treatment** of a disease, illness or injury where that **treatment**:

- falls within the benefits of this **policy** and is not excluded from cover by any term in this handbook; and
- is of an **acute condition** (for details see 3.5); and
- is **conventional treatment** (for details see 3.3); and
- has been proven to be effective and safe (for details see 3.3)
- is not preventative (for details see 4.14); and
- does not cost more than an equivalent **treatment** that delivers a similar therapeutic or diagnostic outcome; and

- is not provided or used primarily for the convenience or financial or other advantage of you or your **specialist** or other health professional.

Treatment needs to meet all of these requirements. There are some exceptions which will be described in the relevant sections of this handbook. For example there are times when we do cover treatment of chronic conditions or unproven treatment. You will find more details of when that is the case in sections 3.3 and 3.5.

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

3.3 > Our cover for treatment and surgery

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

What do you mean by conventional treatment?

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

- is established as best medical practice and is practised widely within the **UK**; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the **treatment** is provided; and has either
  - been approved by NICE (The National Institute for Health and Care Excellence) as a **treatment** which may be used in routine practice; or
  - been proven to be effective and safe for the **treatment** of your **medical condition** through high-quality clinical trial evidence (full criteria available on request).

Are there any additional requirements for drug treatments?

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

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

Are there any additional requirements for surgical treatments?

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

» **To check whether we will agree to cover a treatment, please call us on 0345 600 1292 before you start treatment**

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 Regulations; and
- have moderate or high quality evidence of safety and effectiveness from either:
  - systemic 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. So, we will consider covering the following **treatment** when it is carried out by a **Health For You specialist**:

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

The cover for **unproven treatment** is more restrictive than for **conventional treatments**. **Unproven treatment** must:

- be authorised by us before it takes place; and
- take place in the **UK**; and
- be agreed by us as a suitable equivalent to **conventional treatment** and;
- have high quality evidence of its safety.

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**.

If you receive **treatment** as part of a registered clinical trial we will not cover the costs of the **treatment**, or the **specialist**, hospital or any other costs associated to the trial.

By registered clinical trial we mean a prospectively registered trial in humans registered on the World Health Organisation's International Clinical Trials Platform (https://www.who.int/ictrp/en/) that includes a treatment group (the new treatment) and a control group (either usual care or a placebo).

If we agree to pay for your **unproven treatment**, the amount we pay will depend on how much it costs and how much we would pay if you have **conventional treatment** for your **medical condition** instead.

- If the **unproven treatment** costs less than the equivalent **conventional treatment** we will pay the cost of the **unproven treatment**; or
- If the **unproven treatment** costs more than the equivalent **conventional treatment** we will pay up to the cost we would have paid for the equivalent **conventional treatment**. We will pay up to the amount we would have paid a **Health For You specialist** and hospital in the **hospital list**. To understand what the equivalent **conventional treatment** is we will look at the **treatment** other patients with the same **medical condition** and prognosis would be given.

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

Yes, if you would like an **unproven treatment** you or your **specialist** must contact us at least 10 working days before you book that **treatment**. This is so we can:

- obtain full details of the **unproven treatment** and the supporting clinical evidence; and
- support you with additional information and questions for your **specialist**, before you have **treatment**; and

- agree what costs (if any) we will meet towards the **hospital**, **specialist**, anaesthetist and/or other provider. All **unproven treatment** must be agreed by us in writing, so you are clear how much we will pay towards your **treatment**.

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

We recommend you check with the **hospital**, **specialist**, anaesthetist and/or other provider how much they will charge for your **treatment** so you know how much will be your responsibility to pay.

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

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

- **To check whether we will agree to cover a treatment, please call us on 0345 600 1292 before you start treatment**

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

The information in this section 3.4 does not apply to claims for the following:

- Any benefit under the Dentist and Optician cashback option
- Fees for visits to a private **GP** for consultations
- AXA Doctor at Hand consultations.

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 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 pre-existing condition

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

- you have received medication, advice or **treatment** for in the five years before the start of your cover, or
- you have experienced symptoms of in the five years before the start of your cover:

whether or not the condition was diagnosed.

On your membership statement, you'll see a section called 'Your cover for existing conditions'. This will tell you which underwriting terms you joined on. Here are the options:

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

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

Fully underwritten or full medical underwriting

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

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

Continuing medical exclusions

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

We have listed any special terms or exclusions on your membership statement – please check this carefully. For example, you may not have cover for something specific if you have had that condition in the past. Your statement will also show whether we will remove the exclusion after a period of time.

If we carried on a moratorium from your previous health insurance, the rules of your moratorium may be slightly different, and we may start the moratorium from when it originally began on your previous insurance. Your membership statement will show when your moratorium started.

Medical history disregarded

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

Moratorium (also known as Two Year Watch And Wait)

If you joined us on moratorium terms, it means that you won't have cover for **treatment** of medical problems you had in the five years before you joined us until:

- you've been a member for two **years** in a row, and
- you've had a period of two years in a row, since you joined, that have been **trouble-free** from that condition.

If you have diabetes or raised blood pressure, or you are having **treatment** or being monitored as a result of having a Prostate Specific Antigen (PSA) test (to do with the prostate) that showed abnormal levels, there are some other specified conditions we won't cover **treatment** for. Please see overleaf for more about these.

If you joined us from another health insurer or from a company policy, and we carried on your moratorium from that insurer, the rules may be slightly different, and we may start the moratorium from when it originally began on your previous insurance. Your membership statement will show more details about how your particular moratorium works.

The definition of trouble-free

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

Trouble-free means that you have not done any of the following for the **medical condition** you need **treatment** for:

- had a medical opinion from a medical practitioner, including a **GP** or **specialist**; or
- taken medication (including over-the-counter drugs); or
- followed a special diet; or
- had medical **treatment**; or
- visited any medical practitioner, including but not limited to a **practitioner**, **physiotherapist, homeopath, acupuncturist, chiropractor, osteopath**, optician or dentist.

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

We will exclude **specified conditions** from your cover for at least two years after you join if:

- you had pre-existing diabetes when you joined, or
- you have had treatment for raised blood pressure (hypertension) in the five years before you joined, or
- you have been investigated, monitored or treated as a result of a PSA (Prostate Specific Antigen) test to do with the prostate in the five years before you joined.

The **specified conditions** we will not cover are listed in the table below. We will not cover **treatment** for these **specified conditions** whatever the cause, even if they were not related to the **pre-existing condition**, and even if they develop after you joined.

Pre-existing conditions when you joined	Specified conditions we do not cover
Diabetes	We will not cover **treatment** for: • 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
If you have had **treatment** for raised blood pressure (hypertension) in the five years before you joined	We will not cover **treatment** for: • 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)
If you have been investigated, monitored or treated as a result of a PSA (Prostate Specific Antigen) test in the five years before you joined	We will not cover **treatment** for: • Any disorder of the prostate

You may be able to claim for these **specified conditions** after:

- you have been a member for two years in a row; and
- you had two years in a row since you joined that have been **trouble-free** from the **pre-existing condition**.

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

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

This means we will not cover **treatment** for any conditions that you should have told us about when we asked, but that you either did not tell us about at all, or that you did not tell us the full extent of. This includes:

- any pre-existing condition, whether you had **treatment** for it or not; and/or
- any previous **medical condition** that recurs; and/or
- any previous **medical condition** that you should reasonably have known about, even if you did not speak to a doctor.

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

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

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

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

Your **policy** does not cover you for conditions that:

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

However, your **policy** will cover short-term **in-patient treatment** of flare-ups of a **chronic condition** – that is, unexpected complications or worsening of a **chronic condition**.

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

- monitoring a **medical condition**; 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.

What are acute conditions and chronic conditions?

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

Acute condition

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

Chronic condition

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

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

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

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

How does this affect my cover for cancer treatment?

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?

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

If you have an out-patient Option, we will make an exception for treating some heart conditions.

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

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

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

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

Whether you have an out-patient Option or not, we will still be here to support you if you are diagnosed with a heart condition. At any time, you can speak to one of our specialist nurses for heart patients. They will be able to give you guidance and information about your condition and the **treatment** you are having.

What other treatment is covered for chronic conditions?

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

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

If you have an out-patient Option, we will cover the following up to your **out-patient** limits:

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

Are there any conditions that are always regarded as chronic?

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

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

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

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

Does my policy cover the full fees charged by specialists?

When your **treatment** is covered and it is provided by a **specialist** who is a **Health For You specialist**, we will pay the charges in full. If you use our Fast Track Appointments service, and you would like us to book your appointment for you we will book it with a **Health For You specialist**.

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

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

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

We strongly recommend that you call us on 0345 600 1292 before you arrange a consultation or treatment so that we can check that you're covered.

What about anaesthetists?

If you think that your **treatment** will involve an anaesthetist, please check with your **specialist** which anaesthetist they will use and let us know before your **treatment** starts. We will then be able to tell you whether they are a **Health For You specialist**.

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

As with other **specialists**, if the anaesthetist is not a **Health For You specialist** but is recognised by AXA PPP healthcare we will pay 60% of the fees that would normally be paid by AXA PPP healthcare. You will be responsible for paying the remaining charges.

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

Fast Track Appointments

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

Just call us on 0345 600 7696.

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

Who will be paid under out-patient Options?

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

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

We will pay for **out-patient diagnostic tests** performed by your **specialist** up to the level shown in chapter 21 of our schedule of procedures and fees.

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

» For more about how we pay specialists, see the Core cover table 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

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

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

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

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

Who will be paid under the Therapies Option?

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

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

- **physiotherapists**
- **acupuncturists**
- **homeopaths**
- **osteopaths**
- **chiropractors**.

We will pay up to the level shown in the Therapies Option table.

If your **GP**, or our Working Body team for **treatment** from physiotherapists, refers you for the **treatment**, you are covered for the **treatment** you need up to an overall maximum of ten sessions in a **year**.

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

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

» You can find our schedule at axappphealthcare.co.uk/fees or call us on 0800 533 5921 and we'll send you a copy

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

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

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

Who will be paid under the Mental Health Option?

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

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

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

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

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

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

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

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

We strongly recommend that you call us on 0345 600 1292 before you arrange a consultation or treatment so that we can check that you're covered.

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

Where can I have treatment?

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

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

If your **treatment** is covered by your **policy**, but you have the **treatment** in a facility not listed in the **hospital list**, we'll pay 60% of the charges from that facility as long as they charge up to the normal rates published and charged by that facility. You will be responsible for paying the remaining charges.

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

- accommodation
- **diagnostic tests**
- using the operating theatre
- nursing care
- drugs
- dressings
- radiotherapy and chemotherapy
- physiotherapy
- surgical appliances that the **specialist** uses during **surgery**.

» For more about how we pay for treatment from specialists, please also see sections 3.6 and 3.7

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

- **out-patient treatment**
- intensive care**.**

» See below for more details about these

Where can I have out-patient treatment?

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

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

- your **treatment** is covered by the plan; 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 the **hospital list.**

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 0345 600 1292 before you are admitted to intensive care so we can tell you if you are covered.

What about treatment on the NHS?

If you have free **in-patient treatment** on the NHS that would have been covered by your **policy**, 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.

Does my policy cover payment for treatment anywhere else?

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

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

We strongly recommend that you call us on 0345 600 1292 before you arrange a consultation or treatment so that we can check that you're covered.

3.9 > General restrictions

High charges

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

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

- a **specialist**
- a **physiotherapist**
- an **osteopath**
- a **chiropractor**
- a **cognitive behavioural therapist**
- a **psychologist**
- a **practitioner**.

Consultations within 10 days of treatment

We will not pay any separate fee that your **specialist** makes for consultations within 10 days of carrying out **surgery**.

Treatment and referrals by family members

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

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

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

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

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

If you're at all unsure about the cover you have with your policy – even if you don't need to claim for it at the moment – please just give us a call on 0345 600 1292. We'll always be glad to explain your cover, and it's often quicker and easier than working it out from the handbook alone.

Any questions?

Just call us on 0345 600 1292 and we'll be very glad to help explain anything that's unclear.

If you want to make a claim, please call us on 0345 600 1292 first and we'll be able to check your cover for you and tell you what to do next.

4.1 > Cancer

The cover you have for **cancer** depends on whether you have Comprehensive Cancer Cover or NHS Cancer Support. Your membership statement will confirm which you have. If you have Comprehensive Cancer Cover the information in 4.1a applies to you. If you have NHS Cancer Support cover the information in 4.1b applies to you.

Experienced dedicated nurses and case managers

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

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

4.1a > Comprehensive Cancer Cover

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

About your cover for cancer treatment

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

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

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

Cash payment for NHS treatment

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

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).

Nurse to give you chemotherapy by intravenous drip at home

We will pay in full for **treatment**:

- at home; or
- somewhere else that is appropriate.

We will pay for a **nurse** to give you chemotherapy to treat **cancer** by intravenous drip:

This is so long as:

- we have agreed the **treatment** beforehand; and
- you would otherwise need to be admitted for **in-patient** or **day-patient treatment**; and
- the nurse is working under the supervision of a **specialist**; and
- the **treatment** is provided through a healthcare services supplier that we have a contract with for this kind of service.

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 (4.1a) to find out how we cover **treatment** for **cancer**.

Alternative support if you chose to have your treatment on the NHS

There are alternative methods of using your **policy** following a diagnosis of cancer. If you should decide to have your **treatment** on the NHS instead of using this **policy** to have private **treatment**, there are options available to you which provide financial assistance.

Please call us before your treatment begins so we can discuss your options and what is available.

☎ If you are diagnosed with cancer - please call us on 0345 600 1292 so we can explain how we can support you.

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.
The table below applies to you if you have Comprehensive Cancer Cover. If you have NHS Cancer Support please go to section 4.1b.

Place of treatment	If I have Comprehensive Cancer Cover, am I covered?
Private hospitals, day-patient units or scanning centres listed in the **hospital list**.	✓ Yes
Chemotherapy by intravenous drip at home.	✓ Yes

Diagnostic	If I have Comprehensive Cancer Cover, 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 as an **in-patient** or **day-patient**.	✓ Yes
CT, MRI and PET scans as an **out-patient**.	✓ Yes
Genetic testing to work out whether you have a genetic risk of developing **cancer**.	× No
Genetic testing proven to help choose the best **eligible treatment**. » **See section 4.14 for more information on genetic tests**	✓ Yes
If you're an **in-patient** or **day-patient**	
Specialist fees for the **specialist** treating your **cancer** when you are an **in-patient** or **day-patient**.	✓ Yes
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 If you have an out-patient Option, the consultations will not come out of your **out-patient** limit. If the consultations are before your diagnosis, consultations are covered as part of your overall **out-patient** limit. » **For more details, see the out-patient Option tables.**
Diagnostic tests as an **out-patient** when performed by or ordered by the **specialist** treating your **cancer**.	✓ Yes If you have an out-patient Option, the tests will not come out of your **out-patient** limit. If the tests are before your diagnosis, consultations are covered as part of your overall **out-patient** limit. » **For more details, see the out-patient Option tables.**

Surgery	If I have Comprehensive Cancer Cover, 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 page 40 for how we define surgery.** » **See page 11 for more about conventional and unproven treatment.**	✓ Yes

Preventative	If I have Comprehensive Cancer Cover, am I covered?
Preventative **treatment**, such as: 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). Vaccines to prevent **cancer** developing or coming back – such as vaccinations to prevent cervical **cancer**.	× No

Drug therapy	If I have Comprehensive Cancer Cover, am I covered?
Out-patient drugs or other drugs that a **GP** could prescribe or could be bought over the counter. This includes drugs or prescriptions you are given to take home if you have had **in-patient**, **day-patient** or **out-patient treatment**.	Please call us about these drugs. We don't cover them, but we can help you apply to get these paid for by the NHS. Call us on 0345 600 1292 and we can talk you through this.
Drug **treatment** to kill **cancer** cells – including: • biological therapies, such as Herceptin or Avastin • chemotherapy.	✓ Yes There is no time limit on how long we cover these drugs. We will cover them if: • they have been licensed by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency, and • they are used according to their licence, and • they have been shown to be effective. Because drug licences change, this means that the drugs we cover will change from time to time. Please call us once you know your treatment plan.
Unproven drugs.	× No There is no cover for unproven drugs or drugs that are being used outside of their licence. **Please see section 3.3 for more information on unproven treatment**.
Other drugs. We cover drugs you need to support you whilst you are having chemotherapy or biological therapy to kill **cancer** cells. For example: • Bone strengthening drugs such as bisphosphonates or Denosumab • Hormone therapy that is given by injection (for example goserelin, also known as Zoladex) • Antivirals, antibiotics, antifungals, anti-sickness and anticoagulant drugs.	✓ Yes. They are covered as long as you have them at the same time as you are having chemotherapy or biological therapy to kill **cancer** cells covered by your **policy**.
Drugs for treating conditions secondary to **cancer**, such as erythropoietin (EPO).	✓ Yes, while you are having chemotherapy that is covered by your **policy**.

Radiotherapy	If I have Comprehensive Cancer Cover, am I covered?
Radiotherapy including when it is used to relieve pain.	✓ Yes
Proton beam therapy (PBT)	✓ Yes We will pay for PBT for: • central nervous system (brain and spinal cord) **cancer** or malignant solid **cancers** in members aged 21 and under • chordomas or chondrosarcomas (types of spine **cancer**) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised) • **cancer** of the iris, ciliary body or choroid parts of the eye (uveal melanoma) which has not spread (metastasised) 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**.
Accelerated charged particle therapies	× No However, there is limited cover for Proton Beam Therapy in the circumstances shown above.

Palliative and end of life care	If I have Comprehensive Cancer Cover, am I covered?
Care to relieve pain or other symptoms rather than cure the **cancer**.	✓ We will provide cover and support throughout your **cancer treatment** even if it becomes incurable. We cover radiotherapy, chemotherapy and **surgery** (such as draining fluid or inserting a stent) to relieve pain.
Donation to a hospice where you are having end of life care, or a donation to a service providing hospice at home care. 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.	✓ £100 for each night. This is a charitable donation paid direct to a registered hospice charity when you are provided free **treatment** in a hospice. ✓ £100 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** in lieu of a residential hospice admission.

Monitoring	If I have Comprehensive Cancer Cover, am I covered?
Follow ups – cover for follow up consultations and reviews for **cancer**.	✓ Yes, so long as you are still a member and have a policy that covers this.
Routine monitoring or checks that a **GP** or someone else in a **GP** surgery (or other primary care setting) could carry out.	× No
Follow up procedures that are for monitoring rather than **treatment.** Some **cancer** patients need procedures to check whether **cancer** is still present or has returned. For example, these could include colonoscopies to check the bowel or cystoscopies to check the bladder.	✓ Yes

Limits	If I have Comprehensive Cancer Cover, what limits are there on **treatment** under my **policy**?
Time limits on **cancer treatment**. Your **policy** covers you while you are having **treatment** to kill **cancer** cells.	None
Money limits on **cancer treatment**.	No specific limits – the same rules apply to your **cancer treatment** as for any other **treatment**.

Other benefits	If I have Comprehensive Cancer Cover, what other benefits are there?
Stem cell or bone marrow transplant. » See 4.23 for more about this	✓ Yes We will cover the reasonable costs for a stem cell or bone marrow transplant as long as: • the stem cell or bone marrow transplant is for the **treatment** of **cancer**; and • it is **conventional treatment** for that **cancer**. 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. Please see section 3.3 for more information on **conventional treatment**.
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 NHS Cancer Support we will not pay for the treatment of cancer. You will need to use the NHS, or pay for the costs of treatment yourself.

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

We will pay if:

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

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

4.2 > Alcohol abuse, drug abuse, substance abuse

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

4.3 > Breast reduction

We do not cover either male or female breast reduction.

4.4 > Chiropody and foot care

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

4.5 > Contraception

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

4.6 > 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 4.37 Treatments, medical or surgical interventions or body modifications

4.7 > Criminal activity

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

4.8 > Diabetes

» Please see sections 3.4 and 3.5 to understand your cover for diabetes and restrictions for other conditions when you have pre-existing diabetes

4.9 > 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.

4.10 > Drugs and dressings

We don't cover drugs, dressings or prescriptions that:

- you are given to take home after you have had **in-patient**, **day-patient** or **out-patient treatment**; 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 of this handbook.**

4.11 > External prosthesis or appliances

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 with us 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 AXA PPP healthcare.

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 206 1808 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.

✓ **Extra cover if you have Comprehensive Cancer Cover**

If you have Comprehensive Cancer Cover, we will pay towards 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 as shown in the table in section 4.1a.

4.12 > Fat removal

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

4.13 > Gender re-assignment or gender confirmation

We do not cover gender re-assignment or gender confirmation **treatment** or anything connected to them in any way such as:

- gender reassignment operations or other surgical **treatment**; or
- any other **treatment**.

4.14 > 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.**

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 **policy**.

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:

1. Listed in the NHS England National genomic test directory and used for the purposes listed in the directory; and

2. 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 PPP healthcare.

4.15 > 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. 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 Dentist and Optician Cashback Option or the Private **GP** Option.

× We do not cover primary care services or **treatment** that would normally be carried out in a primary care setting. This includes any fees for services that a **GP**, dentist or optician could normally carry out.

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

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

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

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

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

If you have the Private GP Cover Option, you have cover for private **GP** consultations as shown in the Private GP Cover Options table.

4.16 > 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.

4.17 > Learning and developmental disorders

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

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

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

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

4.18 > Long sightedness, short sightedness and astigmatism

We do not cover any **treatment** to correct long sightedness, short sightedness or astigmatism.

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

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

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

What is not covered under this Option?

We will not pay towards the cost of:

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

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

What you need to claim cashback

If you want to claim cashback under this Option, please ask your optician for fully itemised receipts for everything you wish to claim for. We cannot pay any claims without an itemised receipt showing how much you have paid. Then call us and we will explain what to do.

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

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

4.20 > Mental health

Our cover for mental health depends on whether you have the Mental Health Option.

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

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

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

This includes:

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

» For more details, see the Mental Health Option table

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

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

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

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

What if my condition goes on for a long time?

Our normal rules on **chronic conditions** apply to mental health problems. So if your condition becomes chronic, unfortunately we may no longer be able to cover your **treatment**. If this happens, we will contact you beforehand so that you can decide whether to start paying for the **treatment** yourself, or to transfer to the NHS.

» For more details, see 3.4

What is not covered under the Option?

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

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

4.21 > Natural ageing

We do not pay for **treatment** of symptoms generally associated with the natural process of ageing. This includes **treatment** for the symptoms of puberty and menopause, including symptoms as a result of medical intervention.

4.22 > Nuclear, biological or chemical contamination and war risks

We do not cover **treatment** you need as a result of nuclear, biological or chemical contamination.

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

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

4.23 > Organ or tissue transplant

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.

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.

4.24 > Pregnancy and childbirth

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

We don't cover the checks or other interventions, such as antenatal and postnatal monitoring and screening, that you will have during pregnancy and birth. However, if you develop a **medical condition** while pregnant or giving birth, we may cover it.

What is covered during pregnancy and childbirth?

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)
- hydatidiform 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**.

☎ If you have a baby, we can often add them to your policy from birth. However, if the baby was born after fertility **treatment** or assisted reproduction, there are a few limits on our cover. Please call us on 0345 600 1292 so we can explain what we can cover.

4.25 > 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
- 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.**
- any other preventative screening or **treatment** to see if you have a **medical condition** if you do not have symptoms; or
- vaccinations.

» See 4.14 Genetic tests

4.26 > PSA tests

» See section 3.4 to understand your cover for disorders of the prostate following investigations, treatment or monitoring after a PSA test.

4.27 > Raised blood pressure (hypertension)

» See sections 3.4 and 3.5 to understand your cover for raised blood pressure (hypertension) and restrictions for other conditions when you have pre-existing raised blood pressure.

4.28 > Reconstructive surgery

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

What is covered?

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

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

☎ Please call us on 0345 600 1292 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. 6 Cosmetic treatment, surgery or products

Reconstructive surgery following breast cancer

What is covered?

In the case of breast **cancer** the first reconstructive **surgery** means:

- one planned **surgery** to reconstruct the diseased breast
- one further planned **surgery** to the other breast, when it has not been operated on, to improve symmetry
- nipple tattooing, up to 2 sessions
- one planned **surgery** to reconstruct the nipple.

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

- Two planned fat transfer **surgeries**.The fat must be taken from another part of your body and cannot be donated by anyone else. Fat transfer operations must take place within three years of your first reconstructive **surgery**.
- One planned **surgery** to remove and exchange implants damaged by radiotherapy **treatment** for breast **cancer**. The removal and exchange 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.

What is not covered?

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

» See also 4.6 Cosmetic treatment, surgery or products

4.29 > 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 the **hospital list**; and
- the **treatment** can't be carried out as a **day-patient** or an **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.

4.30 > 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.

4.31 > Sexual dysfunction

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

4.32 > 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 and from the place you are being treated.

4.33 > 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 a grant or sponsorship (we do not count travel costs in this); or
- are competing for prize money.

4.34 > Sterilisation

We do not cover:

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

4.35 > Teeth and dental conditions

Our cover for treating teeth and dental conditions depends on whether you have the Dentist and Optician Cashback Option.

Cover for all

You do not have cover for treating dental problems or any routine dental care, **treatment** of cysts in the jaw that are tooth related or are of a 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
- removing impacted teeth, buried teeth and complicated buried roots
- removal of cysts of the jaw (sometimes called enucleation).

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

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

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

What you need to claim cashback

If you want to claim cashback under this Option, please ask your dentist for fully itemised receipts for everything you wish to claim for. We cannot pay any claims without an itemised receipt showing how much you have paid. Then call us on 0345 600 1292 and we will explain what to do next.

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

We do not cover any costs for **treatment** you receive outside the **UK**. We do not cover any costs or for **treatment** if you live outside the **UK**. If you are going to live outside of the **UK** please call us on 0800 533 5921, as AXA Global Healthcare UK Limited may be able to offer you an international health insurance plan.

✓ **Extra cover if you have the Travel Cover Option**

If you have the Travel Cover Option, please see the European and Worldwide travel cover handbook for details of your cover for treatment abroad.

4.37 >Treatments, medical or surgical interventions or body modifications that are not covered by your plan

If you are planning **treatment**, medical or surgical intervention or body modification that is not covered by your membership, we will not cover:

- any investigations or tests needed to plan or facilitate that **treatment**, medical or surgical intervention or body modification.
- any further **treatment** needed as a result of your **treatment**, medical or surgical intervention or body modification.

If you had **treatments**, medical or surgical interventions or body modifications previously that would not have been covered by the **plan**, we will not cover:

- further **treatment** or increased **treatment** costs that are a result of the **treatment**, medical or surgical intervention or body modification you had previously, or
- any **treatment** which is connected with the **treatment**, medical or surgical intervention or body modification you had previously.

4.38 > 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.

4.39 > 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 your **policy**.

» **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.

4.40 > Warts

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

4.41 > 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 policy

5.1 > Adding a family member or baby

You can add **family members** to your cover, including babies, at any time. If the baby is born after any kind of fertility **treatment**, assisted reproduction, or you've adopted them, there may be some limits to our cover and we've explained these below.

☎ Please contact us if you wish to add a **family member** or baby To add any **family member** or a new baby to your cover, call us on 0800 533 5921 and we will talk you through how it works.

Who you can add

You can normally add:

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

If you would like to add a new baby to your cover, you can normally do this from their date of birth, so long as you contact us within three months of their birth. We normally will not need details of their medical history.

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

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

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

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

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

5.2 > Making changes to your cover

You can make other changes to your cover, such as adding or removing Options or changing your excess, but only at certain times during your **policy**.

When can I make changes to my cover?

You may be able to change your cover:

- in the 14 days after you receive your **policy** documents
- when you renew – when we send your renewal documents, we will ask if you want to change your cover before you renew
- in the 14 days after you receive your renewal documents.

Please call us so we can talk about the options available to you. Depending on your underwriting style, any pre-existing medical conditions you have and any medical conditions that have developed since you joined, there may be some restrictions or limitations to the cover you can add.

You can add a **family member** or baby at any time. Please call us on 0800 533 5921 to talk about your options.

5.3 > Paying your premium

When you join, and shortly before your **policy** is up for renewal, we'll let you know how much your premium will be. You can then choose to pay a yearly or monthly premium.

How can I pay my premium?

You can pay in any of the following ways:

- Yearly premium by Direct Debit
- Monthly premium by Direct Debit
- Yearly premium by credit card
- Yearly premium by cheque or bank transfer.

Your **policy** documents will tell you exactly when we will collect your payments, or how to send in your cheque.

What happens if I miss a payment?

It is important that you pay your premium when it is due. If you miss a payment, we will cancel your **policy** and we will not pay any claim for any **treatment** that you had after the payment was due.

If you have stopped paying for your **policy**, or you have missed or think you will miss a payment, please call us on 0800 533 5921. We will talk to you about your payment options or alternative cover options.

5.4 > Paying your excess

Your **policy** statement will tell you if you have an excess and how much it is. This section tells you how to pay it.

If you have an excess

If you have excess to your **policy**, you can see the amount on your **policy** statement in your **policy** guide. Here is how excesses work:

- We will take your excess off the amount covered by your **policy** for the first claim for each person in each **policy 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 **policy** claim, we will take the excess off both their claims.
- We only take off the excess once per person per **policy 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 **policy year**. This means that if you incur costs during this **policy year**, we will take the excess off what we pay for your claim. If you then incur more costs in the next **policy 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 533 5921.

» You can find an example of how we work out the excess below

Claims that you do not have to pay an excess for

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

- NHS radiotherapy and chemotherapy cash benefit.
- NHS cash benefit.
- **External prosthesis**
- Consultations with a **GP** at the AXA Doctor at Hand service
- Hotel accommodation benefit
- If you have the Dentist and Optician Cashback Option: any claim for dentist's fees, optician's fees or eye tests.
- If you have Comprehensive Cancer Cover: any claim for wigs, head coverings or hospice donations.

If you would like to change or add an excess

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

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

- within 14 days from when you receive your **policy** documents
- when you renew.

Call us on 0800 533 5921 and we will set this up for you.

An example of how we work out the excess

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

Situation:

- Ann has the Therapies Option, which has a limit of £500 for **out-patient treatment with a physiotherapist, osteopath or chiropractor** (as shown in the Therapies Option table).
- She also has an excess of £100.

Here's how it works:

1 Ann has a medical problem that is covered by her Therapies Option. She claims for £300 of physiotherapy (her first claim for the **year**).

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

3 We then pay the remaining £200.

4 We take the whole £300 cost of the claim off Ann's £500 limit for **therapies treatment** (not just the £200 that we paid). So she now has £200 left for **therapies treatment** for the rest of the **year**.

5 A month later, but in the same **policy year**, Ann needs some more **therapies treatment** that's covered by her Therapies Option. This costs £300. Ann doesn't need to pay any excess, because she has already paid her full excess in this **policy year**. But she only has £200 left from her Therapies Option limit.

So we'll pay £200 towards the cost. Ann will need to pay the remaining £100 herself.

5.5 > Your no claims discount

If you don't make a claim, your no claims discount will increase. The discount builds every **year** that you don't claim, up to a maximum of 80%.

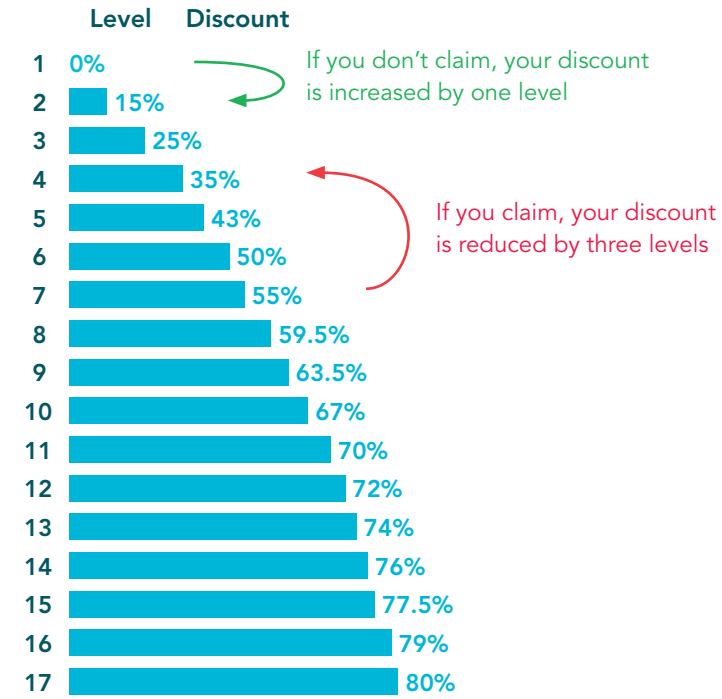
How does the no claims discount work?

Your **policy** statement shows the amount of discount for each person covered on your **policy**.

The discount will apply to all or part of your premium depending on the Options you have.

If we pay a claim for anyone on your **policy,** we will reduce the amount of the discount for that person by three levels until the discount reaches zero. We will do this when you renew. So if anyone on your policy claims and they currently have a 50% discount, it will go down to 25%.

If anyone on your **policy** does not make a claim, their discount increases by one level at renewal, until they get to the maximum 80% discount.



When do you work out the discount for next year?

We work out your discount up to three months before your renewal date. This means that if you make a claim in the three months before your renewal, this may not affect your discount until the following **year's** renewal.

Do you date claims from when I receive treatment or from when you pay the claim?

When working out your discount, we use the date we paid a claim, regardless of when you received the **treatment**.

So if you received **treatment** on 1 January and we paid for it on 14 January, the date of your claim would be 14 January.

What do you count as a claim?

If we pay any money, no matter how little, we count this as a claim when working out your discount.

There are a few exceptions to this rule. We will not count claims for:

- any claim that is lower than your excess amount, and you pay the full amount
- cash benefits: this includes money we pay you if you:
  - choose to have your **treatment** on the NHS (NHS cash benefit)
  - choose to have **day-patient** or **out-patient** radiotherapy or chemotherapy on the NHS (Day-patient or out-patient NHS radiotherapy and chemotherapy cash benefit)

- cashback for opticians' charges or eye tests
- cashback for dentists' charges
- Hotel accommodation benefit
- **External prosthesis**
- claims under the Therapies Option
- claims under the Private **GP** Cover Option
- claims for consultations with a **GP** at the AXA Doctor at Hand service
- hospice donations.

If I want to keep my discount, should I pay for treatment myself?

If you pay for your **treatment** yourself or have it on the NHS, this will not affect your discount level. So if your **treatment** only costs a small amount, when you come to renew your membership, you can choose to pay us back for any claims we have paid during the previous year. We will then re-calculate your no claims discount and subscription.

You have 30 days from after the date of your renewal to pay us back.

Can I protect my no claims discount?

In some cases, we may offer you the chance to protect your no claims discount for a small fee. If you want to do this please contact us within 30 days of receiving your renewal documents.

What happens if I have protected my no claims discount and someone claims?

If someone on your **policy** makes a claim and their no claims discount is protected, their no claims discount will be kept at the same level when the **policy** renews. In other words, we will not reduce their discount, but will not increase it either. They won't be able to carry on protecting their no claims discount. If the claim falls within the no claims discount calculation period, no claims discount protection will be lost for the next **policy year**.

5.6 > Cancelling your policy

Cancelling your policy during the cooling off period

You can cancel up to 14 days from the the start date or renewal date of your **policy**, or the day that you receive the full **policy** terms and conditions whichever comes later. This is known as the cooling off period. If you cancel during this period, you will not have to pay anything, as long as you have not made a claim within that period.

If you make a claim and we pay for your **treatment** during your cooling off period, we will take payment for the **policy** services that we have provided. This means we will take some costs off any amount we refund to you.

If you do not cancel your **policy** within the cooling-off period your **policy** will continue for a **year** so long as you continue paying your premiums.

Cancelling your policy outside of the cooling off period

After your cooling off period:

- if you pay monthly you can cancel your **policy** from the next monthly payment date.
- if you pay annually you can cancel your **policy** and receive a pro-rata refund based on whole months remaining in the year. We will deduct an administration fee of £20 and the costs of any claims for that **year**.

If you cancel during the **year** we will not pay for any claim for **treatment** you were given after the date of cancellation. Please call us on 0800 533 5921 to cancel your **policy** or discuss other options.

5.7 > What happens if you move abroad

If you move outside of the **United Kingdom**, you won't be able keep your current **policy** and you will not be able to make any claims for **treatment**.

Please call us on 0800 533 5921 to discuss your options.

5.8 > 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 **policy**.

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.

5.9 > Why premiums change

Premiums for health insurance tend to increase every year, regardless of which health insurance company you use.

Why does my premium increase every year?

There are a number of reasons why the cost of your health insurance could increase. We review premiums each year and make calculations based on a number of factors. Two of the more common reasons are because:

- Your premiums will tend to rise as you get older. This is because, unfortunately, as we get older we all tend to suffer more health issues.
- The cost of medical **treatment** tends to rise too as new and better ways of diagnosing and treating diseases are developed. We regularly review our policies to keep them up to date and to include new tests and **treatments** where we can.

Please note that your premium also includes Insurance Premium Tax and any other taxes relevant to your **policy**.

What happens if my premium is changing?

Your premium will only change at renewal or if you change something about your **policy** during the **year**. We will tell you about any changes to your premium in plenty of time.

Is there anything I can do to reduce my premium?

There are a few things that you may be able to do to reduce your premium. For example you can:

- add an excess, or set a higher excess – we offer excesses up to at least £500
- add a 6 week option, where you can go private if the NHS cannot treat you within six weeks of when your treatment should happen
- change your Options to give you different cover.

Please call us on 0800 533 5921 and we can talk about your options.

5.10 > Making a complaint

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

Please call us on 0800 533 5921.

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

If you bought your **policy** through a broker and your complaint is regarding the way your **policy** was sold to you, please contact the broker who sold the **policy** to you.

Answering your complaint

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

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

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

The Financial Ombudsman Service

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

The Financial Ombudsman Service
Exchange Tower
Harbour Exchange Square
London
E14 9SR

Phone: 0300 123 9 123 or 0800 023 4567

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

Website: financial-ombudsman.org.uk

Your legal rights

None of the information in section 5.10 affects your legal rights.

6 Legal information

6.1 > Rights and responsibilities

This section sets out the rights and responsibilities we have to each other.

Your policy

Your **policy** is for one **year**.

You must pay the premium for your **policy** when the premium is due.

In return for you paying the premium, we will provide you with the cover set out in your **policy**.

We will pay for covered costs under the terms of this **policy** 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 **policy**. We will not pay for **treatment** that happens outside your period of cover even if we had pre-authorised it during your period of cover under the **policy**.

The provision of the **treatment** itself, including the date(s) of the **treatment**, will be the subject of a separate agreement between you and your **treatment** provider.

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

Sales

When we sell our policies directly to customers we provide information to help customers make the right decisions for their needs but we do not offer a personal recommendation for any of our policies. You may also have bought your **policy** through an intermediary or broker, in which case they will inform you whether they offer a personal recommendation.

Renewal

Before the end of each **policy year**, we will contact the **policyholder** to tell them the terms the **policy** will continue on if the **policy** is still available. We will renew the **policy** on the new terms unless the **policyholder** asks us to make changes or tells us they wish to cancel.

We will collect your premium using the same payment method that you used for the previous **policy year**.

If the **policy** you were on is no longer available, we will do our best to offer you an alternative.

Providing us with information

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

If you change your address, you must write to tell us your new address.

Cooling off period

The 14-day cooling off period starts on the later of the following:

- the start date or renewal date of the **policy**
- the day that the **policyholder** receives the full **policy** terms and conditions.

The **policyholder** may cancel the **policy** during the 14-day cooling off period. If they want to do this, they need to contact us to tell us.

If the **policy** is cancelled during the 14-day cooling off period, we will return any premium paid for the **policy**. The exception to this is if one or more claims have been made relating to cover during the 14-day cooling off period.

If a claim is made during the 14-day cooling off period, the **policyholder** may have to pay for any services we have actually provided in connection with the **policy** to the extent permitted by law. We may deduct this from any returned premium.

Our right to refuse to add a family member

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

Subrogated rights

We, or any person or company that we nominate, have subrogated rights of recovery of the **policyholder** or any **family members** in the event of a claim. This means that we will assume

the rights of the **policyholder** or any **family members** to recover any amount they are entitled to that we have already covered under this **policy**.

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

The **policyholder** 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 your policy

If you break any terms of your **policy** 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 **policy**;
- impose different terms to the cover;
- end your **policy** 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 **policy** 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 **policy** if you or a **family member** are directly or indirectly subject to economic sanctions, including sanctions against your country of residence. We will do this even if you have permission from a relevant authority to continue cover or premium payments under a **policy**. In this case, we can cancel your **policy** or remove a **family member** immediately without notice, but will then tell you if we do this. If you know that you or a **family member** are on a sanctions list or subject to similar restrictions you must let us know within 7 days of finding this out.

Our right to make changes to your policy

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

Law applying to your policy

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

Language for your policy

We will use English for all information and communications about your **policy**.

Legal rights

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

6.2 > Our authorisation and regulation details

AXA PPP healthcare Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority (FCA) and the Prudential Regulation Authority.

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

Our financial services register number is 202947.

You can check details of our registration on the FCA website: fca.org.uk

6.3 > The Financial Services Compensation Scheme (FSCS)

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

- providing financial assistance to the insurer
- transferring policies to another insurer
- paying compensation to policyholders.

The Scheme was established under the Financial Services and Markets Act 2000 and is administered by the Financial Services Compensation Scheme Limited. You can find more information about the scheme on the FSCS website: fscs.org.uk.

6.4 > Your personal information

Here is a summary of the data privacy notice that you can find on the AXA PPP healthcare website axappphealthcare.co.uk/privacy-policy.

Please make sure that everyone covered by this **policy** reads this summary and the full data privacy notice on the AXA PPP healthcare website. If you would like a copy of the full notice call us on 0800 533 5921 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 your **policy** 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 **policy** 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 your **policy** 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 your **policy** properly.

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

If you want to ask to exercise any of your rights just call us on 0800 533 5921 or write to us at Continuous Improvement Team, AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL.

If you want to contact the Data Protection Officer you can do so at Data Protection Team, Jubilee House, Vale Road, Tunbridge Wells, Kent TN1 1BJ.

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 or contributed to by another person

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

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

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

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

In the event you recover our Outlay and interest and do not repay us this recovered amount in full we will be entitled to recover from you what you owe us and your plan may be cancelled in accordance with 'What happens if you break the terms of your policy' on page 36.

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

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

If you have any questions please call 0800 048 1206 and ask for the Third Party Recovery team.

7 Glossary

Certain terms in this handbook have specific meanings. The terms and their meanings are listed in this glossary.

Where we've highlighted these terms in bold they have a specific meaning.

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

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

» **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.

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

- is fully registered under the Medical Acts
- specialises in chiropractic treatment
- is registered under the relevant Act
- is recognised by AXA PPP healthcare as a chiropractor for **out-patient treatment**.

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

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

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

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

- practices cognitive behavioural therapy
- is recognised by us AXA PPP healthcare as a cognitive behavioural therapist.

We will pay for **treatment** by a cognitive behavioural therapist if both the following apply:

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

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

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

conventional treatment - **treatment** that:

- is established as best medical practice and is practised widely within the **UK**; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the **treatment** is provided; and has either
  - been approved by NICE (The National Institute of Health and Care Excellence) as a **treatment** which may be used in routine practice; or
  - been proven to be effective and safe for the **treatment** of your **medical condition** through high-quality clinical trial evidence (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.

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

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

eligible treatment - is **treatment** of a disease, illness or injury where that **treatment**:
- falls within the benefits of this plan and is not excluded from cover by any term in this handbook; and
- is of an **acute condition** (see 3.5); and
- is **conventional treatment** (for details see 3.3); and
- is not preventative (for details see 4.14); and
- does not cost more than an equivalent treatment that is as likely to deliver a similar therapeutic or diagnostic outcome; and
- is not provided or used primarily for the convenience of financial or other advantage of you or your **specialist** or other health professional.

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

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

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

family member – 1) the **policyholder's** current spouse or civil partner or any person living permanently in a similar relationship with the **policyholder**; and 2) any of their or the **policyholder's** children.

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

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

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

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

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

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

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

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

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

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

medical device - any instrument, apparatus, appliance, software, implant, reagent, material or other article intended by the manufacturer to be used, alone or in combination, for human beings.

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

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

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

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

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

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

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

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

policyholder – the first person named on your policy statement. If the first person named on the policy statement is under 18 then a parent or guardian will be named as the policyholder. In this case, the policyholder will not be entitled to cover under this **policy**.

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

private hospital – a hospital listed in the current **hospital list**.

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

We will pay for **treatment** by a psychologist if both the following apply:
- a **specialist** refers you to them
- the **treatment** is as an **out-patient**.

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

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

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

specialist – a medical practitioner who meets all of the following conditions:
- has specialist training in an area of medicine, such as training as a consultant surgeon, consultant anaesthetist, consultant physician or consultant psychiatrist
- is fully registered under the Medical Acts
- is recognised by AXA PPP healthcare as a specialist.

The definition of a specialist who we recognise for **out-patient treatment** only is widened to include those who meet all of the following conditions:
- specialise in musculoskeletal medicine, sports medicine or podiatric surgery.
- is fully registered under the Medical Acts
- is recognised by AXA PPP healthcare as a specialist.

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

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

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

therapist – a medical practitioner who meets all of the following conditions:
- is a practitioner in physiotherapy, osteopathy or chiropractic treatment
- is fully registered under the relevant Acts
- is recognised by **AXA PPP healthcare** as a therapist for **out-patient treatment**.

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

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

United Kingdom (UK) – England, Scotland, Wales and Northern Ireland. Please note, this excludes the Channel Islands and the Isle of Man.

year – the 12 months from your **policy** start date or last renewal date.

How to get in touch

Questions about your policy
0800 533 5921
Monday to Friday 8am to 6pm

Claims
0345 600 1292
Monday to Friday 8am to 6pm

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

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

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health-on-line