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HEALTH AND SAFETY
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PPP HEALTHCARE

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Be Life Confident

VIP, EXECUTIVE & BUSINESS EXPRESS

Membership Information
What you need to know
October 2005

PPP HEALTHCARE

Be Life Confident

Membership handbook

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Welcome to your membership handbook

Contact us

Personal Advisory Team 0800 454 080

Our team of Personal Advisers is available when **you** require **treatment** or want to discuss your membership. They are ready to take your calls in complete confidence, at the times below:

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

Health at Hand – confidential information service 0800 003 004

A team of healthcare professionals is available for health information and to answer your health related questions anytime – day or night, 365 days a year.

Our website – www.axappphealthcare.co.uk

Visit **our** website for further information on:

Health at Hand – to gain access to over 150 medical condition fact sheets and email your health questions to a team of medical professionals.

Directory of Hospitals and information about specialists – to obtain further details on the hospitals listed in the **Directory of Hospitals** (including addresses and hospital details) and also further information on the medical **specialists we** recognise for benefit.

Travel Insurance – with details of our range of travel products and to join on-line.

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

1 Introduction

What is the purpose of this handbook?

This handbook sets out the terms of your cover. It is an important document as it details:

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

Each section of this handbook looks at a different aspect of your cover and is set out in a similar style. At the beginning of each section **you** will find a short summary of the terms in that section, in a question and answer format. This is followed by a table containing more detailed **policy** wording.

Throughout your handbook certain words and phrases appear in **bold type** to indicate they have a special medical or legal meaning. **You** will find a glossary of these words on pages 42–45.

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

Contacting us

While it is important that **you** read and understand your **policy** handbook, **we** understand that it is often easier to call **us** to obtain information. So **we** have a team of Personal Advisers to help **you**.

You should always call **our** team of Personal Advisers on 0800 454 080 when **you** need **treatment** so **we** can help **you** to understand the extent of your cover before **you** incur any **treatment** costs.

Calls may be recorded in case of subsequent query.

2 Your cover

The purpose of your policy

2.1 In return for payment of the premium **we** agree to provide cover as set out in the terms of this **policy**.

2.2 This **policy** is designed to cover **you** for the diagnosis and/or necessary active **treatment** of a **medical condition**:

- when your general practitioner (GP) or dentist refers **you** to an appropriate **specialist**;
- provided the charges actually incurred are for items listed in your **benefits table** and subject to any limits shown there;
- until the **treatment** becomes long-term;

except when the **treatment** is excluded by the **policy**.

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

2.3 The full terms of the insurance contract between the **policyholder** and **us** are set out in the current versions of the following documents, which are sent to the **policyholder** from time to time:

- any application form **we** ask **you** to fill in
- any Statements of Fact **we** have sent **you**
- the terms set out in this handbook and the **benefits table** setting out your cover
- your membership statement and **our** letter of acceptance
- the **Directory of Hospitals**.

2.4 **We** will consider your claims carefully against all the terms, benefits and exclusions set out in this **policy** which should all be read together.

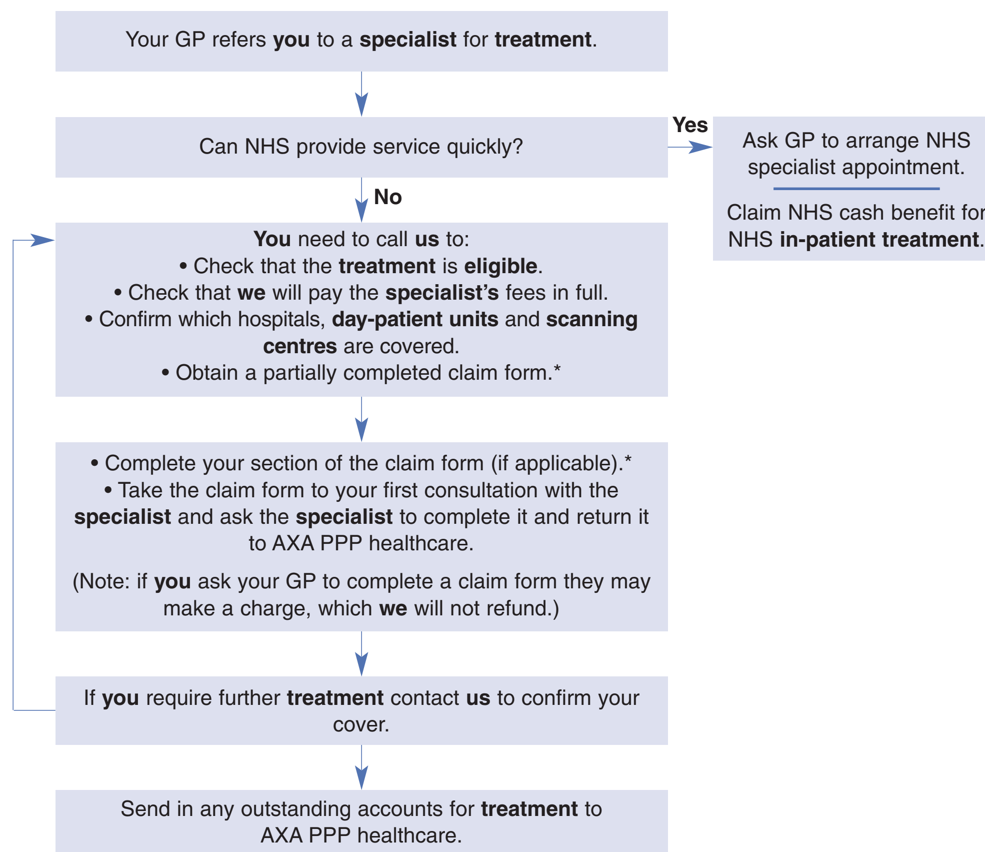
What levels of cover do I have?

Your **benefits table** on page 33 to 41 provides full details of the individual benefits of your cover along with any monetary limits applied to those benefits.

3 Receiving treatment and making a claim

How to arrange treatment and make a claim

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



In many cases a claim form may not be required.

What happens if I require emergency treatment?

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

How are my medical bills settled?

We normally receive accounts for **treatment** directly from **specialists** or hospitals. However, if **you** receive an account for payment, please forward it to **us**. **We** can settle **eligible** bills direct with the hospital or **specialist**, subject to any excess. If **you** have paid the accounts, then **we** will reimburse **you**.

What must I provide when making a claim?

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

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

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

Do I need to provide any other information?

3.2 It may not always be possible to assess the eligibility of your claim from the claim form (or patient's declaration and consent form) alone. In such situations **we** may require additional information and it is your responsibility to provide any reasonable additional information to enable **us** to assess your claim.
In order to establish the eligibility of any claim, **we** may request access to your medical records including medical referral letters. If **you** refuse to agree to such access **we** will refuse your claim and will recoup any previous monies that **we** paid in respect of that **medical condition**.

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

What should I do if I have cover on another insurance policy?

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

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

3.5 **You** must tell **us** on the claim form (if applicable) or patient's declaration and consent form if **you** can claim any of the cost from anyone else. If benefits are claimed for **treatment** to **you** when the injury or **medical condition** was caused by some other person (the 'third party'), **we** will pay those benefits **you** can claim under the **policy**. If another insurance policy covers those benefits then **we** will only pay **our** proper share of the benefits. However, in paying those benefits, **we** obtain both through the terms of the **policy** and by law a right to recover the amount of those benefits from the third party. In this case, the following shall apply:

- **you** must tell **us** as quickly as possible if a third party caused the injury or **medical condition** or if they were at fault. **We** may then write to **you** if **we** require further information; and
- **you** (or your solicitors) must keep **us** fully informed about the progress and outcome of any action; and
- **you** must include all monies paid by **us** in respect of the injuries (and interest on those monies) in your claim against the third party ("**our** outlay"); and
- should **you** successfully recover any monies from the third party (whether in full or part settlement) **you** will pay **our** outlay or in the event that **you** recover only a percentage of your claim for damages the same percentage of **our** outlay directly to **us** within 21 days of the recovery. If **you** do not repay to **us** such monies (and any interest), **we** shall be entitled to recover the same from **you**; and
- any global settlement will be deemed to include recovery of **our** outlay in the same proportion as the global settlement bears to the total claim for damages.

4 New medical conditions

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

Medical insurance is designed primarily to provide cover for **treatment** of new **medical conditions** that arise after **you** join. This is the usual position. However, **you** may have joined on a different basis in which case that fact will be shown on your membership statement.

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

In some circumstances the terms will be that **we** provide cover for **treatment** of pre-existing **medical conditions** after a qualifying period of two **years** from your date of enrolment. If these are your terms then **you** should read the exclusion carefully. To help **you** understand it the important points are:

a) **You** will initially get no cover at all for **treatment** of any **medical condition** which was in existence at any time during the five **years** immediately preceding the date on which **you** joined AXA PPP healthcare. This exclusion relates not only to those conditions for which **you** had already received a firm diagnosis but also to any **medical condition** for which **you** actually had symptoms, even though no diagnosis had been attached to those symptoms. All that matters is that **you** know, or ought reasonably to have known, that something was wrong even if **you** had not consulted a doctor. If **you** make a claim in the early **years** of the **policy**, therefore, **we** will ask for the doctor's confirmation that **you** would have had no reason to know or believe, when **you** joined, that **you** might have the condition for which **you** are claiming.

b) **Treatment** of all such conditions is completely excluded from the cover for two **years** from the date of joining.

c) At the end of those two **years you** will be able to claim for **treatment** of those conditions but only if:
   (i) **You** have not had any medical **treatment** or any medical advice, or taken any drugs or medicines, or followed any special diets in respect of that condition for the period of one **year** (or two **years** depending upon the precise wording of your own clause) immediately before the **treatment** starts.
   (ii) If **you** have had such **treatment** within the period of one **year** (or two **years**) then **you** won't be able to claim for those conditions until such time as **you** have gone for a period of one **year** (or two **years**) without any **treatment** or advice or help or drugs.

It follows that there are some **medical conditions** – those which continue or keep recurring – for which **you** will never be able to make a claim. This is because **you** will always need to have medical advice or take medication and therefore will not be able to go for a period of one **year** (or two **years**) without advice or medication. Those conditions are therefore completely excluded from the cover for all time.

4.1 **We** pay for **eligible**:

(a) **Treatment** of a **medical condition** that arises after **you** join and for **eligible treatment** of any other **medical condition** specifically detailed on your membership statement as included for benefit.

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

➔ (a) **Treatment** received during the first 24 months after **you** joined for any **medical condition** (including **treatment** for a **related condition**) which **you** already had or which **you** should reasonably have known about when **you** joined and which **you** should have told **us** about even if **you** had not consulted a doctor. This includes any such **medical condition(s)** or symptoms, whether or not being treated, and any previous **medical condition(s)** which **you** already had but for which **you** had not received any medical advice or any kind of **treatment** or prescription for the five years immediately before the date on which **you** joined.
At the end of those two **years you** will be able to claim for those conditions but only if **you** have not had any medical **treatment** or any medical advice, or taken any drugs or medicines, or followed any special diets in respect of that condition for the period of one **year** (or two **years** depending upon the precise wording of your own clause) immediately before the **treatment** starts. If **you** have had such **treatment** within the period of one **year** (or two **years**) then **you** won't be able to claim for those conditions until such time as **you** have gone for a period of one **year** (or two **years**) without any **treatment** or advice or help or drugs.

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

5 Type of treatment

Will my policy cover me for preventive treatment?

No, this **policy** has been designed to provide cover for necessary and active **treatment** of disease, illness or injury. Therefore, **we** do not pay for preventive **treatment** or for tests to establish whether a **medical condition** is present when there are no apparent symptoms. **We** do not pay for genetic tests, when those tests are undertaken to establish whether or not **you** may be genetically disposed to the development of a **medical condition**.

What other treatments are not covered?

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

5.1 **We** pay for **eligible**:	5.2 What **we** do not pay for:
(a) **Diagnostic tests** ordered by a **specialist**.	→ (a) **Diagnostic tests** ordered by anyone other than a **specialist**. (b) **Treatment** which is not medically necessary or which may be considered a matter of personal choice. (c) Vaccinations, routine preventive examinations or preventive screening. (d) Preventive **treatment**. (e) Out-patient drugs or dressings. (f) The costs of providing or fitting any external prosthesis or appliance.
(b) Initial reconstructive surgery to restore function or appearance after an accident or following surgery for a **medical condition**, provided that: • **we** have covered **you** continuously under a **policy** of **ours** since before the accident or surgery happened • **we** agree the cost of the **treatment** in writing before it is done.	→ (g) Cosmetic (aesthetic) surgery or **treatment**, or any **treatment** relating to previous cosmetic or reconstructive **treatment**. (h) The removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons (including but not limited to breast reduction).

5.1 **We** pay for **eligible**:	5.2 What **we** do not pay for:
(c) **Treatment** of astigmatism where the astigmatism arises from the surgical replacement of the lens of the eye.	→ (i) Any other **treatment** of astigmatism or any other refractive errors. (j) Any **treatment** to correct long or short-sightedness. (k) **Treatment** directed towards developmental delay in children whether physical or psychological or due to learning difficulties. (l) Any charges which **you** incur for social or domestic reasons (such as travel or home help costs) or for reasons which are not directly connected with **treatment**. (m) Any **treatment** needed as a result of nuclear contamination, biological contamination or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed. (n) Claims on this **policy** if **you** live outside the **United Kingdom** or any **treatment** received outside the **United Kingdom** except as set out in your Travel Cover handbook.

Will my policy cover me for dental treatment?

No, there is no cover for **treatment** provided by a dentist or for any dental procedures or orthodontics. There are some oral **surgical procedures** which **we** will cover. **We** will pay for those oral **surgical procedures** when your dentist refers **you** directly either to a **facility** with which **we** have an agreement to provide a range of oral **surgical procedures** or, where **we** do not have such an agreement to a **specialist,** at another **private hospital**. **We** recommend that **you** call **us** prior to receiving any **treatment** to ensure that the **treatment you** need will be covered.

5.3 **We** pay for **eligible**:

(a) Oral **surgical procedures** listed below following referral by a dentist either to a **facility** with which **we** have an agreement for the provision of oral **surgical procedures** or, where **we** do not have such an agreement to a **specialist**, at another **private hospital**:
- replantation of your own teeth following a trauma
- surgical removal of impacted teeth, buried teeth and complicated buried roots
- enucleation (removal) of cysts of the jaw.

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

(a) Any general dental procedure or for orthodontics.

Will my policy cover me for new or experimental treatments?

Your **policy** only covers **you** for established medical **treatments**. There is no cover for any **treatment** or procedure that has not been established as being effective or which is experimental.

5.5 **We** pay for **eligible**:

(a) **Surgical procedures** listed in a technical document, called the schedule of procedures, which **we** send to **specialists** and which lists the **surgical procedures we** pay benefits for. **We** will pay for **treatment** not listed if, before the **treatment** begins, it is established that the **treatment** is recognised as appropriate by an authoritative medical body and **we** have agreed with the **specialist** what the fees will be.
If **you** would like a copy of the schedule of procedures please contact **us**.

(b) Reasonable costs incurred for a live donor to donate an organ or tissue provided that:
- the operations to both the donor and the recipient are carried out simultaneously; and either
- both the donor and the recipient are immediate relatives (ie parent, child or sibling) and either the donor or the recipient is covered on this **policy**; or
- both the donor and the recipient are members of AXA PPP healthcare at the time the operations are carried out and both have been members since before the recipient developed the **medical condition** requiring the transplant.

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

(a) **Treatment** which has not been established as being effective or which is experimental.

(b) The cost of collecting donor organs or tissue or for any related administration costs (such as, but not limited to, the cost of a donor search).

Childbirth, pregnancy and sexual health

Our position on cover for childbirth, pregnancy and sexual health is detailed below.

5.7 **We** pay for **eligible**:

(a) **Treatment** of the following **medical conditions** (Executive & VIP only):
- ectopic pregnancy (where the foetus is growing outside the womb)
- hydatidiform mole (abnormal cell growth in the womb)
- post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
- retained placental membrane (afterbirth left in the womb after childbirth)
- miscarriage or when the foetus has died and remains with the placenta in the womb.

(b) The cash benefit for childbirth as shown in the **benefits table**.

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

(a) Any costs related to pregnancy or childbirth or for **treatment** of a **medical condition** relating to pregnancy or childbirth such as but not limited to caesarean sections and forceps delivery. (As an exception **we** will pay for the **treatment** of the **medical conditions** detailed in 5.7(a) for Executive & VIP only).

(b) Termination of pregnancy or any consequences of it.

(c) Investigations into and **treatment** of infertility, contraception, assisted reproduction, sterilisation (or its reversal) or any consequence of any of them or of any **treatment** for them.

(d) **Treatment** of impotence or any consequence of it.

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

6 Recurrent, continuing and long-term treatment

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

Your **policy** covers **treatment** of **medical conditions** that respond quickly to **treatment** – defined in **our** glossary as **acute conditions.** If **you** have VIP cover level one this **policy** also provides cover for the routine out-patient management of certain **specified chronic conditions**.

Cover for chronic conditions

This **policy** is not intended to cover **you** against the costs of recurrent, continuing or long-term **treatment** of **chronic conditions**. However, if **you** have VIP cover level one **we** will pay for the out-patient management of certain **specified chronic conditions** as detailed in this handbook.

We define a **chronic condition** in the glossary on page 42 as:

A disease, illness or injury which has at least one of the following characteristics:

- it continues indefinitely and has no known cure
- it comes back or is likely to come back
- it is permanent
- **you** need to be rehabilitated or specially trained to cope with it
- it needs long-term monitoring, consultations, check-ups, examinations or tests.

Your **policy** will cover **you** for the following phases of **treatment** for a **chronic condition**:

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

In the unfortunate event that the **treatment you** are receiving becomes recurrent, continuing or long-term, the costs for **treatment** of that **chronic condition** (including long-term monitoring, consultations, check-ups and examinations) will not be covered under your **policy**. **We** will write to let **you** know if this is the case. However, on VIP cover level one the out-patient management of certain **specified chronic conditions** is covered as detailed on page 15

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

Cover for specified chronic conditions (VIP cover level one only)

If **you** have VIP cover level one this **policy** also covers **you** for out-patient routine follow-up consultations and associated **diagnostic tests** (but not out-patient drugs and dressings) with a **specialist** for the purpose of monitoring the on-going control of a **specified chronic condition** up to the levels allowed in the **benefits table**.

We define what **we** mean by a **specified chronic condition** in the glossary on page 42 as: angina, asthma, diabetes, epilepsy, heart valve problems, high blood pressure, glaucoma, osteoarthritis, rheumatoid arthritis, thyroid problems and ulcerative collitis.

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

We publish a leaflet which explains how **we** deal with payment for **treatment** of **chronic conditions**. This is available on **our** website: www.axappphealthcare.co.uk and can also be obtained from **us**. **You** will also find further explanation of how **we** deal with payment for cancer **treatments** on page 16.

6.1 We pay for eligible:

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

(b) (VIP cover level one only) Out-patient routine follow-up consultations (and associated out-patient **diagnostic tests**) with a **specialist** for the purposes of monitoring the on-going control of a **specified chronic condition**.

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

(d) Initial diagnosis and immediate **treatment** of HIV infection, when **we** will pay **in-patient treatment** benefit for one stay of up to 28 days. →

(e) In-patient rehabilitation of up to 28 days when it is an integral part of **treatment**; and

- it is carried out by a **specialist** in rehabilitation

6.2 What we do not pay for:

(a) Ongoing, recurrent or long-term **treatment** of any **chronic condition** except as allowed in 6.1.

(b) The monitoring of a **medical condition** except as allowed by 6.1(b).

(c) Any **treatment** which only offers temporary relief of symptoms rather than dealing with the underlying **medical condition** except as allowed by 6.1(b).

(d) Routine follow-up consultations except as allowed by 6.1(b).

(e) Regular or long-term kidney dialysis in the case of chronic kidney failure.

(f) **Treatment** of any **medical condition** which arises in any way from HIV infection once the initial diagnosis has been made.

6.1 **We** pay for **eligible**:

- it is carried out in a recognised rehabilitation hospital or unit which is either listed in the **Directory of Hospitals** or which **we** have written to confirming it is recognised by **us**
- the costs have been agreed by **us** before the rehabilitation begins.

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

(e) Hormone replacement therapy (HRT) only when it is medically indicated for the **treatment** of menopause resulting from medical intervention, when **we** will pay for the **specialist** consultations and for the cost of the implants (but not patches or tablets). **We** will only pay benefits for a maximum of 18 months from the date of the medical intervention. → see 6.2 (g)

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

(g) Any hormone replacement therapy (HRT) except for the **treatment** of menopause resulting from medical intervention.

Your cover for cancer and psychiatric illness

Will my policy cover me for cancer treatment?

Your **policy** covers the investigation and active **treatment** of cancer, whether this is a new cancer or a recurrence of an earlier one. This includes surgery, radiotherapy or chemotherapy, alone or in combination. In order to treat your cancer **you** may need these **treatments** repeated as part of the initial **treatment** or for recurrences. These claims will be **eligible** provided they are actively treating the cancer and the **treatment** is for a limited period.

We do not pay benefit where the **treatment** is preventive, for maintenance purposes, or is continuing without a clear end date. For example, in some cancers hormone **treatment** is given every month for many years to help prevent recurrence. Such ongoing **treatments** are not **eligible** although if they are given by injection, **we** would pay for up to three months to allow the **treatment** to be established.

Please remember:

- If **you** have exclusions because of your past medical history which relate to cancer, then **you** will not be covered for any reoccurrence of that cancer.
- Your **policy** does not cover **you** for experimental or unproven **treatment**.
- **We** do not pay for temporary relief of symptoms under your **policy**.

What cover do I have for psychiatric treatment?

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

Note: There is no cover for the **treatment** of psychiatric illness on Business Express.

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

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

6.3 **We** pay for **eligible**:

(a) (VIP and Executive only) **Treatment** of psychiatric illness. **We** have an agreement with psychiatric hospitals regarding **in-patient treatment** of psychiatric illness under which the hospital will contact **us** directly to confirm whether cover is available. → see 6.4 (a)

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

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

(b) (Business Express only) **treatment** of any psychiatric illness.

7 Where you are covered for treatment

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

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

All hospitals listed in **our Directory of Hospitals** have been assessed by **our** quality assessment team. They all have:

- procedures in place to safeguard standards of care
- specified clinical staffing levels
- a doctor on site 24 hours a day
- properly maintained emergency/resuscitation equipment
- a continuous quality improvement programme.

Not only do **we** choose hospitals that maintain high standards of care, **we** also consider the value for money they provide. **Our** aim is to ensure that the costs for the services provided are at an appropriate level and that consequently cover remains affordable.

If **we** are unable, after reasonable negotiation, to conclude the **Agreement** in whole or part, it may be necessary from time to time for **us** to suspend the use of a hospital, **day-patient unit** or **scanning centre** listed in the **Directory of Hospitals** so as to protect the interests of all **our** customers. In such an event **we** will indicate the suspension on **our** website: www.axappphealthcare.co.uk. From time to time part of the **Agreement** may be that **we** will cover charges in full at certain **private hospitals** only for customers whose policies are for cover level one, because those hospitals have higher charges. In such an event, if **you** have cover level two and choose to receive **in-patient treatment** in one of those hospitals, then **we** will only pay the cash benefit shown as benefit 6 in the **benefits table**. To be assured of cover, please call **our** team of Personal Advisers in advance of any **treatment**.

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

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

If **you** have **in-patient treatment** or **day-patient treatment** in any private hospital which **we** do not list in the **Directory of Hospitals** then **we** will pay **you** only a small cash benefit shown as benefit 2 in the **benefits table. You** will be entirely responsible for paying the hospital bills.

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

Which scanning centres are covered?

Your **policy** includes cover for computerised tomography (CT), magnetic resonance imaging (MRI) scans and positron emission tomography (PET). If **you** require CT, MRI or PET **we** will make full payment, or set the charges against any excess **you** may have, if **you** use a **scanning centre** listed in the **Directory of Hospitals**. If **you** use a scanning centre that is not listed in the **Directory of Hospitals**, then **we** will only pay the cash benefit shown as benefit 13(ii) in the **benefits table**.

7.1 We pay for eligible:

(a) Charges made by, or incurred in, a **private hospital**, **day-patient unit** or **scanning centre** listed in the **Directory of Hospitals**. If **you** receive **treatment** in any other hospital, day-patient unit or scanning centre **we** will pay only the cash benefit shown in the **benefits table**, unless

- it is medically necessary to use another facility and **we** have specifically agreed to this in writing before the **treatment** begins; or
- the admission was an emergency and it was medically necessary for **you** to be admitted to another hospital. In this case **we** will pay the hospital's customary charges as long as **we** are notified of the admission as soon as is reasonably practicable.

7.2 What we do not pay for:

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

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

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

(b) Charges made for the use of an out-patient surgical facility with whom **we** have an agreement, when those charges are made to provide a **surgical procedure** on an **out-patient treatment** basis.

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

(d) NHS cash benefit, as shown on the **benefits table**, for each night **you** receive free **treatment** in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.

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

➔ (c) Charges made for the use of an out-patient surgical facility to provide a **surgical procedure** on an **out-patient treatment** basis, unless that facility has an agreement with **us** for such a charge.

➔ (d) Any charges made by, or incurred in an NHS hospital for ITU **treatment**, except as allowed for by 7.1(c).

8 Who we pay for treatment

Your **policy** provides benefit for **eligible treatment** provided by **specialists**, **complementary practitioners** and **clinical practitioners. You** will find **our** definitions of **specialist**, **complementary practitioner** and **clinical practitioner** in the glossary on pages 42–45.

How do I find out whether the person I am seeing for treatment is recognised for benefit?

You should ring **us** before receiving any **treatment**. This will allow **us** to check **our** database and confirm whether the person **you** have been referred to is **eligible** for benefit. In addition, **you** could check the AXA PPP healthcare website: www.axappphealthcare.co.uk which provides relevant information about the **specialists we** recognise.

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

Specialists' fees for consultations, **diagnostic tests**, **treatment** in hospital and **surgical procedures** are **eligible** for benefit, subject to any limits of this **policy**.
Clinical practitioners' (with the exception of physiotherapists') charges for **treatment** are only covered if **you** are referred to them by your **specialist** for **eligible treatment**.
Complementary practitioners' and physiotherapists' charges for **treatment** are covered when **you** are referred to them by your GP for **eligible treatment** subject to any limits of this **policy**. **We** would then pay up to an overall maximum of 10 sessions of **treatment** a **year** with a physiotherapist and/or a **complementary practitioner** if **you** have cover level two. If **you** have cover level one **we** will pay up to an overall maximum of 20 sessions of **treatment** a **year** with a physiotherapist and/or a **complementary practitioner**. If **you** require more than the overall maximum for your cover level, such **treatment** must be under the control of a **specialist**. The **specialist** will then be able to establish whether the **treatment you** are receiving is the most appropriate form of **treatment** for your particular **medical condition**.

Will charges for these services be met in full?

Your **policy** provides full reimbursement of **specialists', complementary practitioners'** and **clinical practitioners'** fees which are charged within the range that is usual for that service, subject to any limits of this **policy**. This means that **we** pay the **eligible** charges made by most **specialists, complementary practitioners** and **clinical practitioners** in full. Where **you** are charged more than is usually charged, **we** will limit benefit to the average

charge for the service provided. Some **specialists**, **complementary practitioners** and **clinical practitioners** may ask **you** to pay the difference when this occurs. **We** have identified those **specialists**, **complementary practitioners** and **clinical practitioners** whose fees **we** may not pay in full.

How can I find out whether I will be expected to pay the difference?

You should ring **us** so **we** will be able to confirm whether the charges will be met in full. **You** can also check **our** website for a list of **specialists** whose fees **we** meet in full. Where this is not the case **we** recommend that **you** ask your **specialist**, **complementary practitioner** or **clinical practitioner** for an estimate of charges so that **we** can tell **you** how much **we** will pay. Where **you** are receiving services in hospital provided by a **specialist** other than the **specialist** to whom **you** were initially referred, such as a radiologist or pathologist, it is unlikely that **you** will be able to check whether **we** will pay their charges in full before **treatment** takes place. For that reason **we** have arrangements with most hospitals to include their fees in the hospital charges. This allows **us** to guarantee payment of their charges in full. Where no such arrangement exists, particularly in regard to anaesthetists' charges, **we** will make every effort to notify **you** when **you** may be expected to meet all or part of their charges.

8.1 **We** pay for **eligible**:

(a) **Treatment** charges made by a **specialist** only when **you** are referred to one by a GP or dentist.
We will pay up to the level customarily charged by **specialists** generally for the services received. If necessary **we** will delay paying the claim until **we** are satisfied that the charges are appropriate.

(b) **Treatment** charges made by a **clinical practitioner** or **complementary practitioner** when **you** are referred to one by the treating **specialist**.
However if your GP refers **you** for **treatment** with a physiotherapist and/or a **complementary practitioner** **we** will pay up to an overall maximum of 10 sessions of **treatment** a **year** if **you** have cover level two. If **you** have cover level one **we** will pay up to an

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

(a) Charges made by anyone other than a **specialist**, **complementary practitioner** or **clinical practitioner** including charges for primary care services, such as any services of a GP or dentist.

(b) Charges for general chiropody or foot care even if this is carried out by a surgical podiatrist.

(c) Charges made by a **clinical practitioner** when your GP refers **you** to one. **We** will pay for GP referred physiotherapy as set out in 8.1(b).

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

(e) Out-patient drugs or dressings.

8.1 **We** pay for **eligible**: 8.2 What **we** do not pay for:

overall maximum of 20 sessions of **treatment** a **year** with a physiotherapist and/or a **complementary practitioner**.
If more than the overall maximum number of sessions of **treatment** with a physiotherapist and/or a **complementary practitioner** are required, they must be referred by and be under the personal control of a **specialist**.

(c) **We** will pay up to the level customarily charged by **clinical practitioners** and **complementary practitioners** generally for the services received.
If necessary **we** will delay paying the claim until **we** are satisfied that the charges are appropriate.

9 Treatment abroad

What overseas cover do I have on my policy?

This **policy** does not provide any cover for **treatment** received outside the **United Kingdom**. However, your **company** may have purchased travel cover from **us**. If this is the case this will be reflected on your membership statement and **you** should read your Travel Cover handbook for details of your overseas cover.

10 Health at Hand

How could Health at Hand help me?

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

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

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

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

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

Family Clinic – babies, toddlers, teenage trouble, pregnancy or retirement.
Care and Counselling Clinic – stress, addiction, depression or bereavement.
Healthy Living Clinic – exercise, diet, drinking, smoking, and cholesterol control.
Travel Clinic – inoculations, taking children abroad and medical advice by country.
Pills and Prescriptions Clinic – medicines, side effects and pain relief.
Women's Health Clinic – fertility, screenings, menopause and osteoporosis.
Men's Health Clinic – prostate issues, testicular cancer, impotence and fertility.

Health at Hand – 0800 003 004

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

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

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

11 Additional benefits for cover level one

What cover do I have for accidental death?

We will pay £15,000 for VIP, £10,000 for Executive or £5,000 for Business Express if **you** have an **accident**, which results in your death solely and independently of any other cause and within 90 days of such **accident**. If **you** die, your personal representative should let **us** know as soon as possible. **We** will send that person a claim form and ask them for the original death certificate or a certified true copy together with Grant of Probate or Letters of Administration to support the claim.

12 Additional information

When can I add other members?

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

What happens to my cover if I change jobs or retire?

If the **policyholder** changes jobs or retires, your AXA PPP healthcare corporate cover will end on the last day of employment with your **company**. **You** won't have to give up your AXA PPP healthcare membership though, because **you** can join as an individual member and if **you** join within a limited period after **you** leave your **company you** can do so without any need for additional underwriting. It's easy for **you** to continue enjoying the benefit of AXA PPP healthcare cover and **you** can call **us** free on 0800 028 2915 if **you** want to find out more.

Can I add my new baby to my policy?

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

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

You will need to change your cover to an international policy if **you** go to live abroad or if **you** stay or intend to stay outside the **United Kingdom** for a total of more than six months in a **year**. Please call **us** as soon as **you** know **you** are going abroad. **We** have a range of international policies that have more appropriate benefits for anyone living abroad.

Will I have to pay income tax on the premiums?

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

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

If **you** have an excess on your **policy**, this is how it is applied.

- The excess (that is, the amount of money **you** have to pay towards the cost of **eligible treatment**) applies to every person covered by the **policy** in each **policy year**.
- **We** will not pay any claim or part of a claim which is subject to an excess. In this case **we** will only pay the balance of the claim after **we** have deducted the excess amount.

- The excess is deducted from any **eligible treatment** costs **you** incur.
- The excess is a single deduction that is made regardless of the number of individual **medical conditions** claimed for in that **policy year**. Should **treatment** continue beyond your **policy's** renewal date then **we** will apply the excess once against the costs incurred before this date, and again against the costs incurred on or after the renewal date. **We** will do this irrespective of whether the costs relate to **treatment** for the same **medical condition**.
- **We** will not apply the excess against medical costs for **treatment** that your **policy** does not cover.

Here are two examples of how the excess operates:

Example 1 (with a £100 excess).

If for example a **policy** has a benefit limit of £1,000 (for each person each **year**) for out-patient consultations, **diagnostic tests, complementary practitioners'** and **clinical practioners'** charges.

- **You** then develop a medical problem and require £300 of **eligible diagnostic tests** – your first claim for that **policy year**.
- At this stage the £100 excess charge is applied.
- This means **we** pay £200 towards the £300 cost of **out-patient treatment** while **you** pay the £100 excess.
- This £300 total claim reduces your £1,000 benefit limit for out-patient consultations, **diagnostic tests, complementary practitioners'** and **clinical practitioners'** charge to £700.
- Later in the same **policy year**, **you** suffer a different **medical condition** incurring costs of £750 for **eligible** out-patient consultations and **diagnostic tests** – £50 more than the **policy's** remaining £700 benefit limit.
- Therefore **we** pay £700 towards the cost of **treatment**, and **you** pay the £50 shortfall.

Example 2

- Based on the same details as in example 1, now suppose that your first bill for **out-patient treatment** was £1,050 instead of £300. The position would be different.
- Because the **policy's** benefit limit for out-patient consultations, **diagnostic tests, complementary practitioners'** and **clincial practitioners'** charges is £1,000, this means that, straight away, the **policy** will not cover £50 of the £1,050 bill.
- Therefore the claim works out like this: £1,000 for **treatment** – less the £100 excess – means that the **policy** pays out £900 in total.
- Leaving no further benefit for out-patient consultations, **diagnostic tests, complementary practitioners'** and **clinical practitioners'** charges for the rest of the **policy year.**

How is my personal data protected?

We will deal with all personal information **you** supply to **us** in the strictest confidence as required by the Data Protection Act (1998). **We** extend the same duty of confidentiality to any third parties to whom **we** may subcontract the administration of your **policy**, including those based outside the European Economic Area.

We will use your personal information to provide the services set out under the terms of this **policy** and to administer your **policy**. As the **policyholder** is acting on behalf of any **family member** covered by this **policy**, **we** will send all correspondence about the **policy**, including any claims correspondence, to the **policyholder** unless **we** are advised to do otherwise. In certain circumstances **we** may ask medical service providers (or others) to supply **us** with further information.

We may contact **you** by post, telephone, or electronically with details of **our** other products and services. **We** may also share some of your details with other AXA Group companies and other carefully selected companies based in the European Economic Area to enable them to contact **you** about their products and services and, if appropriate to administer them. If **you** do not wish **us** to do this please contact **our** team of Personal Advisers otherwise **we** will assume that, for the time being, **you** are happy to be contacted in this way.

We may disclose information about anyone under your **policy** when there is a legal requirement for **us** to do so or in circumstances when it would help **us** to prevent or investigate fraud or improper claims.

What regulatory protection do I have?

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

The FSA have set out rules which regulate the sale and administration of general insurance which **we** must follow when **we** deal with **you**. **Our** FSA register number is 202947.
This information can be checked by visiting the FSA register which is on their website: www.fsa.gov.uk/register or by contacting the FSA on 0845 606 1234.

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

We are also participants in the Financial Services Compensation Scheme established under the Financial Services and Markets Act 2000. The scheme is administered by the Financial Services Compensation Scheme Limited (FSCS), a body established by the FSA. The scheme is governed by FSA Rules and may act if it decides that an insurance company is in such serious financial difficulties that it may not be able to honour its contracts of insurance.
The scheme may assist by providing financial assistance to the insurer concerned, by transferring policies to another insurer, or by paying compensation to eligible policyholders.

For non-compulsory insurance the scheme pays the first £2000 of a valid claim in full and 90% of the remaining amount of your loss.

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

What should I do if I have reason to complain?

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

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

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

If **you** think things have gone wrong for **you** and **you** are unhappy with **us**, please contact **our** team of Personal Advisers in the first instance and they will try to resolve your complaint. However, if **you** are unhappy with their response, then **we** invite **you** to write to:

The Customer Relations Executive
AXA PPP healthcare
Phillips House
Crescent Road
Tunbridge Wells TN1 2PL

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

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

The Operations Director
AXA PPP healthcare
PPP House
Vale Road
Tunbridge Wells TN1 1BJ

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

The Financial Ombudsman Service

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

The Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London E14 9SR
Telephone: 0845 080 1800
Email: enquiries@financial-ombudsman.org.uk
Website: www.financial-ombudsman.org.uk

The Ombudsman will review complaints about:

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

Please note that the Ombudsman will not normally investigate complaints concerning an insurer's exercise of commercial judgement. For example, disputes about premium increases or a decision to exclude a **medical condition** from cover will not generally be considered.

The Ombudsman will also not usually review a complaint where:

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

None of these procedures affect your legal rights.

Legal rights and responsibilities

12.1 Your rights and responsibilities

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

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

(c) **You** must write and tell **us** if **you** change your address.

(d) Only the **policyholder** and **we** have legal rights under this **policy** and it is not intended that any clause or term of this **policy** should be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999, by any other person including any **family member**.

(e) If your cover under the **company agreement** comes to an end **you** can apply to transfer to another **policy**.

12.2 AXA PPP healthcare's rights and responsibilities

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

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

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

(d) If **you** break any of the terms of the **policy** **we** can:
- refuse to make any benefit payment or if **we** have already paid benefits **we** can recover from **you** any loss to **us** caused by the break; and
- refuse to renew your **policy**; or
- impose different terms to any cover **we** are prepared to provide; or
- end your **policy** and all cover under it immediately.

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

12.3 Your company's rights and responsibilities

(a) Your **policy** is for one **year**. At the end of that time, provided the **policy** **you** are on is still available, the **company** can renew it on the terms and conditions applicable at that time which **we** shall notify to **you**. **You** will be bound by those terms.

(b) Only those people described in the **company agreement** can be members of this **policy**.

(c) All cover ends when the **policyholder** stops working for the **company** or if the **company** decides to end the cover.

13 Benefits table for Business Express

This table shows the benefits available to **you** for the cost of **treatment**. These benefits are explained fully in the preceding pages of your handbook. **You** must read this table in conjunction with the rest of your handbook.

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

	Benefits	Benefit level	Where can I find more information?
	In-patient & day-patient treatment		
1.	**Private hospital** and **day-patient unit** charges: including charges for accommodation, **diagnostic tests**, operating theatre charges, nursing care, drugs and dressings, physiotherapy, and surgical appliances used by the **specialist** during surgery.	Paid in full within your cover level at a **private hospital** or **day-patient unit** listed in the **Directory of Hospitals**.	Pages 18–20
2.	Out of directory cash benefit. This benefit is payable if **you** receive private **in-patient treatment** or **day-patient treatment** at a hospital or day-patient unit not listed in the **Directory of Hospitals**.	£50	Page 19
3.	**Specialists**' fees (Surgeons', anaesthetists' and physicians').	No annual maximum	Pages 21–23
4.	In-patient consultations – benefit for a consultation with a second **specialist** arranged by the treating **specialist**	No annual maximum	Pages 21–23
5.	Parent accommodation – this benefit is for the cost of one parent staying in hospital with a child under 11 years old while the child is receiving **eligible** private **treatment**. The child must be covered by the **policy** and the benefit is paid from the child's benefits.	Paid in full within your cover level.	
6.	Higher hospital cover (applicable if **you** have cover level two) for **in-patient treatment** in the **United Kingdom**. Note: This will only be applied in the unlikely event that **you** choose to use a **private hospital** which is only available to cover level one customers. At the time of going to print there were not such hospitals listed and therefore currently this benefit is not applicable.	£400	Pages 18–20

	Benefits	Benefit level	Where can I find more information?
	Out-patient treatment		
7.	**Surgical procedures**.	No annual maximum	Pages 21–23
8.	**Specialist** consultations.	Cover level one: These four benefits (8, 9, 10 and 11) have a combined overall limit of £750 a **year**. Cover level two: These four benefits (8,9,10 and 11) have a combined overall limit of £500 a **year**. Within the above limit **we** will pay for up to an overall maximum of ten sessions of **treatment** a **year** for GP referred physiotherapy and/or **complementary practitioner treatment** if **you** have cover level two. If **you** have cover level one **we** will pay within the above combined overall limit up to an overall maximum of 20 sessions of **treatment** a **year** with a physiotherapist and/or a **complementary practitioner**.	Pages 21–23
9.	**Diagnostic tests** on **specialist** referral.		Pages 21–23
10.	**Clinical practitioner** charges (including physiotherapy).		Pages 21–23
11.	**Complementary practitioner** charges.		Pages 21–23
12.	Radiotherapy (the use of radiation to treat cancers) and chemotherapy (the use of drugs to treat cancers).	No annual maximum	Page 16
13.	(i) Computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET). (ii) Out of directory scanning cash benefit. This benefit is payable for using a CT, MRI or PET facility not listed as a **scanning centre** in the **Directory of Hospitals**.	Paid in full in a **scanning centre** listed in the **Directory of Hospitals**. £50	Page 18–20
	Other benefits		
14.	Ambulance transport – when **you** are receiving private **in-patient treatment** or **day-patient treatment** and it is medically necessary to use a road ambulance to transport **you** between a hospital and another medical facility.	Paid in full	

	Benefits	Benefit level	Where can I find more information?
	Other benefits continued		
15.	NHS cash benefit. This benefit is paid for each night **you** receive free **treatment** under the NHS and only if: (i) **you** are admitted for **in-patient treatment** before midnight (ii) the **treatment you** receive under the NHS would have been **eligible** for benefit privately under this **policy**. There is no requirement for private **treatment** to have preceded any period in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.	£50 a night up to £5,000 a **year**.	Page 19
16.	Childbirth benefit. **We** will pay this cash benefit for each birth occurring after the mother has been covered by this **policy** for ten consecutive months or more.	£100	Page 13
17.	Travel Cover.	Optional	Page 24
18	Accidental Death Cover (applicable if **you** have cover level one).	£5,000	Page 26
19.	Health at Hand.	Confidential health information.	Page 25
	Optional excess		
	Excess for each person covered by this **policy** each **year**: Level 1 Level 2 Level 3 Excesses do not apply to NHS cash benefit or childbirth benefit. Under this **policy** there is no cover for **treatment** of psychiatric illness.	 £100 £200 £500	Pages 27–28

Benefits table for Executive

This table shows the benefits available to **you** for the cost of **treatment**. These benefits are explained fully in the preceding pages of your handbook. **You** must read this table in conjunction with the rest of your handbook.
Please make sure **you** call **us** prior to **treatment** so **we** can confirm the extent of your cover and any limitations that may apply.

	Benefits	Benefit level	Where can I find more information?
	In-patient & day-patient treatment		
1.	**Private hospital** and **day-patient unit** charges: including charges for accommodation, **diagnostic tests**, operating theatre charges, nursing care, drugs and dressings, physiotherapy, and surgical appliances used by the **specialist** during surgery.	Paid in full within your cover level at a **private hospital** or **day-patient unit** listed in the **Directory of Hospitals**.	Pages 18–20
2.	Out of directory cash benefit. This benefit is payable if **you** receive private **in-patient treatment** or **day-patient treatment** at a hospital or day-patient unit not listed in the **Directory of Hospitals**.	£50	Page 19
3.	**Specialists**' fees (Surgeons', anaesthetists' and physicians').	No annual maximum	Pages 21–23
4.	In-patient consultations – benefit for a consultation with a second **specialist** arranged by the treating **specialist**.	No annual maximum	Pages 21–23
5.	Parent accommodation – this benefit is for the cost of one parent staying in hospital with a child under 11 years old while the child is receiving **eligible** private **treatment**. The child must be covered by the **policy** and the benefit is paid from the child's benefits.	Paid in full within your cover level.	
6.	Higher hospital cover (applicable if **you** have cover level two): a) for **in-patient treatment** of psychiatric illness b) for other **in-patient treatment** in the **United Kingdom**.	 £200 £400	Pages 18–20
	Note: This will only be applied in the unlikely event that **you** choose to use a **private hospital** which is only available to cover level one customers. At the time of going to print there were no such hospitals listed and therefore currently this benefit is not applicable.		

	Benefits	Benefit level	Where can I find more information?
	Out-patient treatment		
7.	**Surgical procedures**.	No annual maximum	Pages 21–23
8.	**Specialist** consultations.	Cover level one: These four benefits (8, 9, 10 and 11) have a combined overall limit of £1,200 a **year**. Cover level two: These four benefits (8,9,10 and 11) have a combined overall limit of £1,000 a **year**. Within the above limit **we** will pay for up to an overall maximum of ten sessions of **treatment** a **year** for GP referred physiotherapy and/or **complementary practitioner treatment** if **you** have cover level two. If **you** have cover level one **we** will pay within the above combined overall limit up to an overall maximum of 20 sessions of **treatment** a **year** with a physiotherapist and/or a **complementary practitioner**.	Pages 21–23
9.	**Diagnostic tests** on **specialist** referral.		Pages 21–23
10.	**Clinical practitioner** charges (including physiotherapy).		Pages 21–23
11.	**Complementary practitioner** charges.		Pages 21–23
12.	Radiotherapy (the use of radiation to treat cancers) and chemotherapy (the use of drugs to treat cancers).	No annual maximum	Page 16
13.	(i) Computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET). (ii) Out of directory scanning cash benefit. This benefit is payable for using a CT, MRI or PET facility not listed as a **scanning centre** in the **Directory of Hospitals**.	Paid in full in a **scanning centre** listed in the **Directory of Hospitals**. £50	Page 18–20
	Other benefits		
14.	Ambulance transport – when **you** are receiving private **in-patient treatment** or **day-patient treatment** and it is medically necessary to use a road ambulance to transport **you** between a hospital and another medical facility.	Paid in full	

	Benefits	Benefit level	Where can I find more information?
	Other benefits continued		
15.	Hospital-at-home – this is for **treatment** provided at home or another clinically appropriate setting for the administration of intravenous cytotoxic chemotherapy or intravenous antibiotics which otherwise would require **you** to be admitted for **in-patient treatment** or **day-patient treatment**.	Paid in full when **treatment**: • is provided by a **qualified nurse** under the control of a **specialist**; and • is provided through a healthcare services supplier which **we** have a contract with for such services; and • has been agreed by **us** before the **treatment** begins.	
16.	NHS cash benefit. This benefit is paid for each night **you** receive free **treatment** under the NHS and only if: (i) **you** are admitted for **in-patient treatment** before midnight (ii) the **treatment you** receive under the NHS would have been **eligible** for benefit privately under this **policy**. There is no requirement for private **treatment** to have preceded any period in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.	£50 a night up to £5,000 a **year**.	Page 19
17.	Childbirth benefit. **We** will pay this cash benefit for each birth occurring after the mother has been covered by this **policy** for ten consecutive months or more.	£100	Page 13
18.	Travel Cover.	Optional	Page 24
19	Accidental Death Cover (applicable if **you** have cover level one).	£10,000	Page 26
20.	Health at Hand.	Confidential health information.	Page 25
	Optional excess		
	Excess for each person covered by this **policy** each **year**: Level 1 Level 2 Level 3 Excesses do not apply to NHS cash benefit or childbirth benefit.	 £100 £200 £500	Pages 27–28

Benefits table for VIP

This table shows the benefits available to **you** for the cost of **treatment**. These benefits are explained fully in the preceding pages of your handbook. **You** must read this table in conjunction with the rest of your handbook.
Please make sure **you** call **us** prior to **treatment** so **we** can confirm the extent of your cover and any limitations that may apply.

	Benefits	Benefit level	Where can I find more information?
	In-patient & day-patient treatment		
1.	**Private hospital** and **day-patient unit** charges: including charges for accommodation, **diagnostic tests**, operating theatre charges, nursing care, drugs and dressings, physiotherapy, and surgical appliances used by the **specialist** during surgery.	Paid in full within your cover level at a **private hospital** or **day-patient unit** listed in the **Directory of Hospitals**.	Pages 18–20
2.	Out of directory cash benefit. This benefit is payable if **you** receive private **in-patient treatment** or **day-patient treatment** at a hospital or day-patient unit not listed in the **Directory of Hospitals**.	£100	Page 19
3.	**Specialists**' fees (Surgeons', anaesthetists' and physicians').	No annual maximum	Pages 21–23
4.	In-patient consultations – benefit for a consultation with a second **specialist** arranged by the treating **specialist**.	No annual maximum	Pages 21–23
5.	Parent accommodation – this benefit is for the cost of one parent staying in hospital with a child under 11 years old while the child is receiving **eligible** private **treatment**. The child must be covered by the **policy** and the benefit is paid from the child's benefits.	Paid in full within your cover level.	
6.	Higher hospital cover (applicable if **you** have cover level two): a) for **in-patient treatment** of psychiatric illness b) for other **in-patient treatment** in the **United Kingdom**.	 £200 £400	Pages 18–20
	Note: This will only be applied in the unlikely event that **you** choose to use a **private hospital** which is only available to cover level one customers. At the time of going to print there were no such hospitals listed and therefore currently this benefit is not applicable.		

	Benefits	Benefit level	Where can I find more information?
	Out-patient treatment		
7.	**Surgical procedures**.	No annual maximum	Pages 21–23
8.	**Specialist** consultations.	No annual maximum	Pages 21–23
9.	**Diagnostic tests** on **specialist** referral.	No annual maximum	Pages 21–23
10.	**Clinical practitioner** charges (including physiotherapy).	No annual maximum However **we** will only pay for up to an overall maximum of ten sessions of **treatment** a **year** for GP referred physiotherapy and/or **complementary practitioner treatment** if **you** have cover level two. If **you** have cover level one we will pay up to an overall maximum of 20 sessions of **treatment** a **year** for GP referred physiotherapy and/or **complementary practitioner treatment**.	Pages 21–23
11.	**Complementary practitioner** charges (acupuncturists, osteopaths, chiropractors and homeopaths).		Pages 21–23
12.	Radiotherapy (the use of radiation to treat cancers) and chemotherapy (the use of drugs to treat cancers).	No annual maximum	Page 16
13.	(i) Computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET). (ii) Out of directory scanning cash benefit. This benefit is payable for using a CT, MRI or PET facility not listed as a **scanning centre** in the **Directory of Hospitals**.	Paid in full in a **scanning centre** listed in the **Directory of Hospitals**. £100	Page 18–20
	Other benefits		
14.	Ambulance transport – when **you** are receiving private **in-patient treatment** or **day-patient treatment** and it is medically necessary to use a road ambulance to transport **you** between a hospital and another medical facility.	Paid in full	

	Benefits	Benefit level	Where can I find more information?
	Other benefits continued		
15.	Hospital-at-home – this is for **treatment** provided at home or another clinically appropriate setting for the administration of intravenous cytotoxic chemotherapy or intravenous antibiotics which otherwise would require **you** to be admitted for **in-patient treatment** or **day-patient treatment**.	Paid in full when **treatment**: • is provided by a **qualified nurse** under the control of a **specialist**; and • is provided through a healthcare services supplier which **we** have a contract with for such services; and • has been agreed by **us** before the **treatment** begins.	
16.	NHS cash benefit. This benefit is paid for each night **you** receive free **treatment** under the NHS and only if: (i) **you** are admitted for **in-patient treatment** before midnight. (ii) the **treatment you** receive under the NHS would have been **eligible** for benefit privately under this **policy**. There is no requirement for private **treatment** to have preceded any period in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.	£100 a night up to £5,000 a **year**.	Page 19
17.	Childbirth benefit. **We** will pay this cash benefit for each birth occurring after the mother has been covered by this **policy** for ten consecutive months or more.	£150	Page 13
18.	Travel Cover.	Optional	Page 24
19	Accidental Death Cover (applicable if **you** have cover level one).	£15,000	Page 26
20.	Health at Hand.	Confidential health information.	Page 25
	Optional excess		
	Excess for each person covered by this **policy** each **year**: Level 1 Level 2 Level 3 Excesses do not apply to NHS cash benefit or childbirth benefit.	 £100 £200 £500	Pages 27–28

14 Glossary

Throughout this handbook certain words and phrases appear in **bold**. Where these words appear they have a special medical or legal meaning. These meanings are set out below.

To aid customer understanding certain words and phrases in this glossary have been approved by the Association of British Insurers and the Plain English Campaign. These particular terms will be commonly used by most medical insurers and are highlighted below by a ◆ symbol.

accident – this is when **you** sustain bodily injury caused by accidental external violent and visible means or as a result of a recorded act of negligence.

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

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

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

chronic condition ◆ – a disease, illness or injury which has at least one of the following characteristics:

- It continues indefinitely and has no known cure.
- It comes back or is likely to come back.
- It is permanent.
- **You** need to be rehabilitated or specially trained to cope with it.
- It needs long-term monitoring, consultations, check-ups, examinations or tests.

clinical practitioner – a practising member of certain professions allied to medicine who, in all cases, meets **our** recognition criteria for benefit purposes in their field of practice and who **we** have told in writing that **we** currently recognise them as a **clinical practitioner** for benefit purposes. However, **we** will only pay **out-patient treatment** benefits for such services when a **specialist** refers **you** to them (except where the **benefits table** allows otherwise).

When such persons provide such services to **you** as part of your **in-patient treatment** or **day-patient treatment** those services will form part of the **private hospital** charges. The professions concerned are dieticians, **qualified nurses**, orthoptists, physiotherapists, psychologists, psychotherapists and speech therapists.

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

company – your employer.

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

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

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

day-patient treatment ◆ – **treatment** which, for medical reasons, means **you** have to go into a hospital or **day-patient unit** because **you** need a period of clinically-supervised recovery but do not have to stay overnight.

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

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

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

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

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

family member – the **policyholder's** partner and his/her unmarried children (or those of his/her partner) living with the **policyholder** when the **policy** is taken out or when it is renewed. By partner **we** mean the husband or wife or the person (whether or not of the same sex) the **policyholder** lives with permanently in a similar relationship. Unmarried children cannot stay on your **policy** after the renewal date following their 21st birthday (or 25th birthday if in full-time education).

in-patient treatment ◆ – **treatment** which, for medical reasons, means **you** have to stay in hospital overnight or for longer.

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

out-patient treatment ◆ – **treatment** given at a hospital, consulting room or out-patient clinic where **you** do not go in for **day-patient** or **in-patient treatment**.

policy – the insurance contract between **you** and **us**. Its full terms are set out in the

current versions of the following documents as sent to **you** from time to time:

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

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

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

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

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

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

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

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

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

sports activities covered abroad – +Abseiling, Archery, Badminton, +Ballooning, Baseball, Basketball, Bowls, +Bungee Jumping, *Canoeing, *Catamaran Sailing, Clay Pigeon Shooting, Cricket, Cycling, Dinghy Sailing, Dry Skiing, Fell Running, Fell Walking, Fencing, Fishing, Football, Golf, Gymnastics, +Hang Gliding, +High Diving, Hiking, Horse Riding (but not hunting), Ice Skating, Lacrosse, Land Skiing, Marathon Running, *Mountain Biking, +Mountaineering (unless requiring ropes and guides or freestyle climbing), Orienteering, Paint Balling, +Parachute Jumping (except freefall), +Paragliding, +Parascending, Pony Trekking, Racquetball, Rambling, Roller Skating, Rounders, Rowing, Safari Trekking, *Sailing, Scuba Diving to a maximum depth of ten metres, Shooting, Skiing on Piste, Snorkelling, Squash, Surfing, Swimming, Tennis, Trekking, Volley Ball, War Games, Water Polo, *Water Skiing, +White Water Rafting if part of a Tour Operators excursion, Windsurfing, *Yachting within coastal waters.

There is no cover for sports activities marked with a + when they constitute the main purpose of your trip. There is no cover for sports activities marked with a * when **you** participate in the sport in any competitive capacity.

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

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

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

we/us/our – AXA PPP healthcare.

year – twelve calendar months from when your **policy** began or was last renewed unless **we** have agreed something different with your **company**.

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