

Individual medical insurance

Membership handbook / Ideal range



Please note:

This membership handbook provides information about all of our products in the Ideal range. Therefore, some of this information will not be relevant to you and where this is the case, the text will be shown in greyed out type.

What you need to know

April 2010



PPP HEALTHCARE

redefining / standards

Contacting us

While it is important that **you** read and understand this **policy** handbook, **we** understand that it is often easier to call **us** to obtain information – so **we** have a team of Personal Advisers to help **you**. **You** should always call them on 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.

Quick reference guide for important information

Personal Advisory Team 0800 454 080

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

Health at Hand 0800 003 004

Available: day or night, 365 days a year.
Our health information service. See page 36.

The overseas emergency control centre +44(0) 1892 513 999

Available: day or night, 365 days a year.

www.axapphealthcare.co.uk/members

Available: day or night, 365 days a year.
For information on member offers, products and travel insurance.

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

We are committed to giving customers access to **our** products. To contact **us** by Text Relay 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 Text Relay on 18001 0800 454 080 and Health at Hand can be contacted on 18001 0800 003 004.

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

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1 Introduction

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

This handbook sets out the terms of your cover for the Ideal range of plans. If **you** are unsure of which particular **policy you** have or your cover level, please refer to your membership statement.

This handbook is an important document as it details:

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

Throughout your handbook certain words and phrases appear in **bold type** to indicate they have a special medical or legal meaning. **You** will find a glossary of these words on pages 45–48.

Please note:

This handbook contains information on more than one plan within the Ideal range.

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

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

CL1 Note for cover level one members.

Sections 1 to 10 of this handbook show the standard benefits that are available both to cover level one and cover level two members.

If **you** have cover level one **you** have extended cover. To highlight where this is the case we use a **CL1** symbol. Whenever **you** see this symbol **you** will be referred to Section 11 'Cover level one – Extended benefits.' This section details how your benefits as a cover level one member have been enhanced.

2 Your cover

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

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

Summary of the Ideal Plan

The Ideal **policy** offers **you** cover for necessary **treatment** of new **medical conditions** that arise after **you** join. It does not cover **you** for **treatment** of **medical conditions** that existed, or **you** had symptoms of before joining. However, in some circumstances **you** may have joined on a different basis, please refer to the 'Existing medical conditions' section for further information. There is also no cover for ongoing, recurrent and long-term conditions (also known as **chronic conditions**).

Your cover includes:

- **in-patient** and **day-patient treatment** and associated **specialists'** charges
- **out-patient surgical procedures**
- radiotherapy and chemotherapy
- computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) scans
- up to £900 of benefits for **diagnostic tests**, **out-patient** consultations and **complementary practitioner** and **clinical practitioner** charges (including physiotherapy)
- **treatment** of psychiatric illness.

Ideal 6, Ideal 6 Choice members:

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

Ideal Choice, Ideal 6 Choice members:

With a 'Choice' plan, **you** will be entitled to a no claims discount provided **you** don't make a claim. Please see the accompanying leaflet for details of how your no claims discount is calculated.

Be aware:

Your policy will not cover you for:	For more information:
General dental procedures.	Page 15
Routine pregnancy and childbirth.	Page 18
Ideal 6, Ideal 6 Choice members: Urgent or emergency treatment.	Page 11
Cover level 2 members: Charges when treatment is received outside of our Directory of Hospitals .	Pages 25–26

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

Please note:

We will pay **eligible** fees in full when a **specialist, complementary practitioner** or **clinical practitioner** charges up to the level within **our** published schedule of procedures and fees. Please see the 'Who we pay for treatment' section of this handbook for full details.

3 Benefits table

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

Please make sure **you** call **us** on 0800 454 080 prior to **treatment** so **we** can confirm the extent of your cover and any limitations that may apply.

Please note:

Ideal 6 or **Ideal 6 Choice** Members: These policies will cover the costs of **in-patient** or **day-patient treatment** – or an **out-patient surgical procedure** – if the NHS could not provide that **treatment** within six weeks after the date on which the **treatment** should be undertaken. The only exceptions to this provision are shown in the following paragraph (immediate cover) and, if **you** have **day-patient** or **out-patient** radiotherapy or chemotherapy.

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

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

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

Core cover – applies to all plans

Benefits	Cover level two (amount payable)	Cover level one (amount payable)
In-patient & day-patient treatment		
<p>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.</p>	<p>Paid in full at a private hospital or day-patient unit listed in the Directory of Hospitals.</p>	<p>Paid in full at a private hospital or day-patient unit listed in the Directory of Hospitals and paid up to the normal daily rates for a private hospital or day-patient unit not listed in the Directory of Hospitals.</p>
<p>For more information on the above please see: Pages 25–26 and CL1 pages 33–34</p>		
<p>2. Out of directory cash benefit. This benefit is payable if you receive private in-patient or day-patient treatment at a hospital or day-patient unit not listed in the Directory of Hospitals.</p>	<p>£50 each day for day-patient treatment £50 each night for in-patient treatment</p>	<p>Not applicable</p>
<p>For more information on the above please see: Pages 25–26</p>		
<p>3. Specialists’ fees. (Surgeons’, anaesthetists’ and physicians’).</p>	<p>No annual maximum</p>	
<p>For more information on the above please see: Pages 27–29</p>		
<p>4. In-patient consultations. Benefit for a consultation with a second specialist arranged by the treating specialist.</p>	<p>No annual maximum</p>	
<p>For more information on the above please see: Pages 27–29</p>		
<p>5. Parent accommodation. This benefit is for the cost of one parent staying in hospital with a child under 14 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.</p>	<p>Paid in full</p>	

Core cover – applies to all plans		
Benefits	Cover level two (amount payable)	Cover level one (amount payable)
In-patient & day-patient treatment continued		
6. Psychiatric treatment	Paid in full at a private hospital or day-patient unit listed in the Directory of Hospitals .	Paid in full at a private hospital or day-patient unit listed in the Directory of Hospitals and paid up to the normal daily rates for a private hospital or day-patient unit not listed in the Directory of Hospitals .
For more information on the above please see:		Page 21
Out-patient treatment		
7. Surgical procedures.	No annual maximum	
For more information on the above please see:		Pages 15–18
The following four benefits (8, 9, 10, and 11) have a combined overall limit of £900 a year .		
8. Specialist consultations.	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 .	Within the above limit we will pay for up to an overall maximum of 20 sessions of treatment a year for GP referred physiotherapy and/or complementary practitioner treatment .
9. Diagnostic tests on specialist referral.		
10. Clinical practitioner charges (including physiotherapy).		
11. Complementary practitioner charges.		
For more information on the above please see:		Pages 27–29 and CL1 pages 34–35
12. Radiotherapy (the use of radiation to treat cancers) and chemotherapy (the use of drugs to treat cancers).	No annual maximum	
For more information on the above please see:		Pages 21–24

continued overleaf

Core cover – applies to all plans

Benefits	Cover level two (amount payable)	Cover level one (amount payable)
Out-patient treatment continued		
<p>13. (i) Computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET).</p> <p>(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.</p>	<p>Paid in full in a scanning centre listed in the Directory of Hospitals.</p> <p>£50 each visit</p>	<p>Paid in full in a scanning centre listed in the Directory of Hospitals and paid up to the normal rates for a scanning centre not listed in the Directory of Hospitals.</p> <p>Not applicable</p>
<p>For more information on the above please see: Pages 25–26 and CL1 pages 34–35</p>		
Other benefits		
<p>14. Ambulance transport.</p> <p>When you are receiving private in-patient or day-patient treatment and it is medically necessary to use a road ambulance to transport you between a hospital and another medical facility.</p>	<p>Paid in full</p>	
<p>15. Overseas evacuation or repatriation service. Evacuation and repatriation costs.</p> <p>Immediate emergency in-patient treatment received while travelling abroad which relates to an evacuation or repatriation we have arranged for you.</p>	<p>Paid in full</p> <p>Up to £40,000 a year</p>	<p>Paid in full</p> <p>Up to £100,000 a year</p>
<p>For more information on the above please see: Pages 30–33 and CL1 pages 34–35</p>		
<p>16. Hospital-at-home.</p> <p>This is for treatment provided at home or another clinically appropriate setting for the administration of intravenous chemotherapy for the treatment of cancer or intravenous antibiotics which otherwise would require you to be admitted for in-patient or day-patient treatment.</p>	<p>Paid in full when treatment:</p> <ul style="list-style-type: none"> • is provided by a nurse under the control of a specialist; and • is provided through a healthcare services supplier which we have a contract with for such services; and • has been agreed by us before the treatment begins. 	

Core cover – applies to all plans		
Benefits	Cover level two (amount payable)	Cover level one (amount payable)
Other benefits continued		
<p>17. NHS cash benefit.</p> <p>This benefit is paid for each night you receive free treatment under the NHS and only if:</p> <p>(i) you are admitted for in-patient treatment before midnight</p> <p>(ii) the treatment you receive under the NHS would have been eligible for benefit privately under this policy.</p> <p>Please note:</p> <ul style="list-style-type: none"> • Ideal 6 or Ideal 6 Choice Members: The six week waiting period does not apply to NHS cash benefits. <p>There is no requirement for private treatment to have preceded any period in an NHS intensive therapy unit or NHS intensive care unit.</p>	£50 a night up to £2,000 a year	
For more information on the above please see:	Pages 25–26	
<p>18. Day-patient and out-patient NHS radiotherapy and chemotherapy cash benefit.</p> <p>This benefit is paid for day-patient or out-patient radiotherapy or chemotherapy you receive free under the NHS for the treatment of cancer and only if the treatment you receive under the NHS would have been eligible for benefit privately under this policy.</p>	£50 a day up to £2,000 a year	
For more information on the above please see:	Page 22	
<p>19. Health at Hand. Confidential medical information.</p>	Immediate access 24 hours a day, 365 days a year	
For more information on the above please see:	Page 36	

Optional excess information

Excess for each person covered by these **policies** each **year**:

Option 1: £100 Option 2: £200 Option 3: £500

Excesses do not apply to NHS cash benefit and overseas **evacuation or repatriation service** or the **day-patient** and **out-patient** radiotherapy and chemotherapy cash benefit.

4 Arranging treatment and making a claim

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

Step One	Your GP refers you to a specialist for private treatment .
Step Two	You need to call us on 0800 454 080 to check that the treatment is eligible . Please help us by having the following details available: <ul style="list-style-type: none">• Specialist or group practice name.• Hospital name and any admission dates.• A procedure code if you are having a surgical procedure.
Step Three	We will then: <ul style="list-style-type: none">• Check that we will pay the specialist's fees in full.• Confirm which hospitals, day-patient units and scanning centres are covered.• Send you a partially completed claim form (if applicable).*
Step Four	<ul style="list-style-type: none">• Complete your section of the claim form (if applicable).*• Take the claim form with you when you first go for treatment and ask the specialist to complete it and return it to AXA PPP healthcare.
Step Five	Send in any outstanding accounts for treatment to AXA PPP healthcare. If you require further treatment contact us to confirm your cover.

**In some cases a claim form may not be required.*

Please send any correspondence to:

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

Please note:

Ideal 6 or Ideal 6 Choice Members:

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

Be aware:

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

What happens if I require emergency treatment?

Ideal 6 or Ideal 6 Choice Members: These **policies** will only provide benefit for **in-patient** or **day-patient treatment** and **out-patient surgical procedures** if the NHS cannot provide that **treatment** within six weeks after the date on which the **treatment** should be undertaken.

Be aware:

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

As **you** will appreciate, if **you** have a serious or life threatening condition which needs urgent **treatment** the NHS will treat that condition within six weeks. Your **policy** therefore will not cover it because of its urgent or emergency nature.

If **you** are taken ill while travelling abroad the six week waiting period does not apply, please follow the procedure described on page 30.

Ideal Plan or Ideal Choice Members: 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 core **benefits table**.

If **you** are taken ill while travelling abroad, please follow the procedure described on page 30.

How are my medical bills settled?

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

What must I provide when making a claim?

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

- **you** obtain and complete any form required by **us** in order to provide **us** with the necessary information and necessary legal permissions to handle your medical information and to assess your claim. **We** will require this as soon as possible and no later than six months from the date the **treatment** starts (unless this was not reasonably possible); and
- **we** receive original invoices for **treatment** costs; and
- **you** promptly give **us** all the information **we** request.

Do I need to provide any other information?

- 4.2 It may not always be possible to assess the eligibility of your claim from the claim form (or patient's declaration and consent form) alone. In such situations **we** may require additional information and it is your responsibility to provide any reasonable additional information to enable **us** to assess your claim.

Be aware:

In order to establish the eligibility of any claim, **we** may request access to your medical records including medical referral letters. If **you** unreasonably refuse to agree to such access **we** will refuse your claim and will recoup any previous monies that **we** have paid in respect of that **medical condition**.

- 4.3 There may be instances where **we** are uncertain about the eligibility of a claim. If this is the case, **we** may at **our** own cost ask a **specialist**, chosen by **us**, to advise **us** about the medical facts relating to a claim or to examine **you** in connection with the claim. In choosing a relevant **specialist** **we** will take into account your personal circumstances. **You** must co-operate with any **specialist** chosen by **us** or **we** will not pay your claim.

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

- 4.4 **You** must tell **us** if **you** can claim any of the cost from another insurance policy.

If another insurance policy is involved **we** will only pay **our** proper share.

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

- 4.5 **You** must tell **us** on the claim form (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 **you** believe a third party caused the injury or **medical condition**, or if **you** believe they were at fault. **We** may then write to **you** or the third party if **we** require further information; 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
- **you** (or your solicitors) must keep **us** fully informed about the progress of your claim and any action against the third party or any pre-action matters; and

4.5 continued

- **you** (or your solicitors) must keep **us** informed of the outcome of any action or settlement (providing **us** with access to the details of any such settlement);
- should **you** successfully recover any monies from the third party they should be repaid directly to **us** within 21 days of receipt on the following basis:
 - If the claim against the third party settles in full, **you** must repay **our** outlay in full; or
 - If **you** recover only a percentage of your claim for damages **you** must repay the same percentage of **our** outlay to **us**; or
 - If your claim is repaid as a global settlement (where **our** outlay is not individually identified), **you** must repay **our** outlay in the same proportion as the global settlement bears to your total claim for damages against the third party.

If **you** do not repay to **us** such monies (and any interest recovered from the third party), **we** shall be entitled to recover the same from **you** and your **policy** may be cancelled in line with 14.2(d) in the 'Complaint and regulatory information' section.

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

5 Existing medical conditions

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

As medical insurance is designed primarily to provide cover for **treatment** of new **medical conditions** that arise after **you** join, there is generally no cover for **treatment** of **medical conditions** that existed prior to joining or for **medical conditions** arising from or associated with a **medical condition** that existed prior to joining.

Please note:

In some circumstances **you** may have joined on different terms to those described above and **you** will find those terms on your membership statement. **You** may also have an additional addendum which details the terms that apply.

5.1 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.

5.2 What we do not pay for:

- (a) **Treatment** of any **medical condition** (or **treatment** of any **medical condition** arising from or associated with such a **medical condition**) which **you** already had when **you** joined and which **you** should have told **us** about when we asked but which **you** either:
 - did not tell **us** about at all; or
 - omitted to tell **us** about the full extent of it.

This includes:

- any current or previous **medical condition(s)** or symptoms, whether or not being treated; and
 - any previous **medical condition(s)** which recurs or which **you** should reasonably have known about (even if **you** had not consulted a doctor).
- (b) **Treatment** of any other **medical condition** detailed on your membership statement as excluded for benefit.

How will I know what medical conditions I am not covered for?

If **you** have completed a medical history declaration, your membership statement will show the **medical conditions** we will not cover. Please contact **us** if **you** are in any doubt about the extent of your cover.

6 Your cover for certain types of treatment

Will my policy cover me for preventive treatment?

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

Please note:

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

What other treatments are not covered?

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

6.1 We pay for eligible:

- (a) **Diagnostic tests** ordered by a **specialist**.
- (b) Oral **surgical procedures** listed below following referral by a dentist:
 - replantation of your own teeth following a trauma
 - surgical removal of impacted teeth, buried teeth and complicated buried roots
 - enucleation (removal) of cysts of the jaw.
- (c) Initial reconstructive surgery to restore function or appearance after an accident or following surgery for a **medical condition**, provided that:
 - **we** have covered **you** continuously under a **policy** of **ours** since before the accident or surgery happened
 - **we** agree the cost of the **treatment** in writing before it is done (see also 6.2(i)).
- (d) **Treatment** of astigmatism where the astigmatism arises from the surgical replacement of the lens of the eye (see also 6.2(k)).

6.2 What we do not pay for:

- (a) **Diagnostic tests** ordered by anyone other than a **specialist**.
- (b) Any general dental procedure or for orthodontics.
- (c) **Treatment** which is not medically necessary or which may be considered a matter of personal choice.
- (d) Any **treatment** of warts of the skin.

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

6.2 continued

- (e) Vaccinations, routine preventive examinations or preventive screening.
- (f) Preventive **treatment**.
- (g) **Out-patient** drugs or dressings.
- (h) The costs of providing or fitting any external prosthesis or appliance.
- (i) Cosmetic (aesthetic) surgery or **treatment**, or any **treatment** relating to previous cosmetic or reconstructive **treatment**. (See also 6.1(c)).
- (j) 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).
- (k) Any other **treatment** of astigmatism or any other refractive errors. (See also 6.1(d)).
- (l) Any **treatment** to correct long or short-sightedness.
- (m) **Treatment** directed towards developmental delay in children whether physical or psychological or due to learning difficulties.
- (n) 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**.
- (o) Any **treatment** costs incurred as a result of engaging in any sport as a professional.
- (p) Any **treatment** needed as a result of nuclear contamination, biological contamination or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed. Please note, for clarity: There is cover for **treatment** required as a result of a **terrorist act** providing that **terrorist act** does not result in nuclear, biological or chemical contamination.
- (q) Claims on this **policy** if **you** live outside the **United Kingdom**.
- (r) Any **treatment** received outside the **United Kingdom** except as set out in 10.1(a).
CL1 If **you** have cover level one there is extended cover for **treatment** received overseas, please refer to Section 11 for details.
- (s) **Ideal 6** or **Ideal 6 Choice Members**: Anything outside the terms of cover, which for clarity includes any urgent or emergency **treatment**. **We** also do not pay for **treatment** of any **medical condition** unless recommended **treatment** is not available under the NHS within six weeks after the date on which the required **treatment** should be undertaken. This requirement shall not apply to those **surgical procedures** listed in the core **benefits table** or if **you** are receiving **day-patient** or **out-patient** radiotherapy or chemotherapy.

Will my policy cover me for new or experimental treatments?

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

Be aware:

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

CL1 However, if you have cover level one there is extended cover for experimental surgical procedures please refer to Section 11 for details.

6.3 We pay for eligible:

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

6.4 What we do not pay for:

- (a) The use of a drug which has not been established as being effective or which is experimental. This means they must be licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and be used within the terms of that licence.
- (b) **Treatment** which has not been established as being effective or which is experimental. For established **treatment**, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced in published medical journals and/or approved by The National Institute for Health and Clinical Excellence for specific purposes to be considered proven safe and effective therapies.
- (c) The cost of collecting donor organs or tissue or for any related administration costs (such as, but not limited to, the cost of a donor search).

Childbirth, pregnancy and sexual health

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

Be aware

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

6.5 We pay for eligible:

- (a) Additional costs incurred for the **treatment** of **medical conditions** when they occur during that pregnancy or childbirth. As an illustration **we** would consider **treatment** of the following:
- ectopic pregnancy (where the foetus is growing outside the womb)
 - hydatidiform mole (abnormal cell growth in the womb)
 - retained placenta (afterbirth retained in the womb)
 - placenta praevia
 - eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
 - diabetes (If **you** have exclusions because of your past medical history which relate to diabetes, then **you** will not be covered for any **treatment** for diabetes during pregnancy)
 - post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
 - miscarriage requiring immediate surgical **treatment**
 - failure to progress in labour.

6.6 What we do not pay for:

- (a) Any costs related to pregnancy or childbirth except the additional costs incurred for **eligible treatment** of a **medical condition**.
- (b) Investigations into and **treatment** of infertility, contraception, assisted reproduction, sterilisation (or its reversal) or any consequence of any of them or of any **treatment** for them.
- (c) **Treatment** of impotence or any consequence of it.
- (d) Gender re-assignment operations or any other surgical or medical **treatment** including psychotherapy or similar services which arise from, or are directly or indirectly associated with gender re-assignment.

7 Recurrent, continuing and long-term treatment

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

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

We define a **chronic condition** in the glossary on page 45 as:

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

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

Please note:

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

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

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

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

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

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

We publish a leaflet which explains how we deal with payment for **treatment of chronic conditions**. This is available on **our** website: www.axapphealthcare.co.uk and can also be obtained from **us**. **You** will also find further explanation of how we deal with payment for **cancer treatments** on page 21.

7.1 We pay for eligible:

- (a) **Treatment** of an **acute condition** and the short-term **in-patient treatment** intended to stabilise and bring under control a **chronic condition**.
- (b) Kidney dialysis for up to six weeks during preparation for kidney transplant.
- (c) Initial diagnosis and immediate **treatment** of HIV infection, when we will pay **in-patient treatment** benefit for one stay of up to 28 days.
- (d) **In-patient** rehabilitation of up to 28 days when it is an integral part of **treatment**; and
 - If you have Ideal 6 or Ideal 6 Choice: it immediately follows **eligible treatment**
 - it is carried out by a **specialist** in rehabilitation
 - it is carried out in a recognised rehabilitation hospital or unit which is either listed in the **Directory of Hospitals** or which we have written to confirming it is recognised by **us**
 - the costs have been agreed by **us** before the rehabilitation begins.

We will extend **in-patient** rehabilitation to a maximum of 180 days in cases of severe central nervous system damage caused by an external trauma.
- (e) Hormone replacement therapy (HRT) only when it is medically indicated for the **treatment** of menopause resulting from medical intervention, when we will pay for the **specialist** consultations and for the cost of the implants (but not patches or tablets). We will only pay benefits for a maximum of 18 months from the date of the medical intervention.

7.2 What we do not pay for:

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

What cover do I have for psychiatric treatment?

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

Should **you** require **in-patient** or **day-patient treatment** of a psychiatric condition, the hospital will contact **us** prior to your admission to check whether your **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**.

7.3 We pay for eligible:

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

7.4 What we do not pay for:

- (a) **Treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide.
- (b) **Treatment** of, or **treatment** which arises from or is in any way connected with, alcohol abuse, drug abuse or substance abuse.

Will my policy cover me for cancer treatment?

C.1 Please note: if **you** have cover level one refer to page 34 for details of your extended cover for **cancer**.

You are covered for **treatment** of a new **cancer** which arises after **you** join and for any recurrence of this **cancer**. If **you** have exclusions because of your past medical history which relate to a **cancer**, then **you** will not be covered for any recurrence of **cancer**.

Please refer to Section 5 on page 14 for further information on your cover for pre-existing **medical conditions**.

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

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

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

Please note:

Ideal 6 or Ideal 6 Choice Members: This cover is subject to the restrictions on this **policy** on:

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

NHS or private?

Whilst **you** are covered for **eligible cancer treatment** on this **policy** you may decide that **you** want to receive **treatment** on the NHS. If **you** are diagnosed with **cancer** you will be referred to one of **our** nurse case managers. They will be able to give **you** information on the **treatment** options open to **you** and support **you** through your **treatment**.

Should **you** choose to receive your **treatment** as an NHS patient **you** will be **eligible** to receive the NHS cash benefits shown in the **benefits table** on page 9, when **you** receive **eligible day-patient** or **out-patient** radiotherapy or chemotherapy **treatment** or **eligible in-patient treatment**. **Our** nurse case managers will also be able to discuss other services which **we** can arrange, to support **you** whilst **you** are receiving NHS **cancer treatment**, for example transport assistance, childcare or domestic help.

The following table is a summary of the cover provided for **cancer** under this **policy** and should be read alongside the rest of the handbook, including the **benefits table** on pages 5–9.

Summary of Cancer cover for Ideal Range		
	Cover	
Where am I covered for treatment?	✓	Treatment of cancer at a private hospital, day-patient unit or scanning centre listed in our Directory of Hospitals. CL1 If you have cover level one you have extended cover for treatment received outside the Directory of Hospitals . Please refer to Section 11 for details.
	✓	Intravenous chemotherapy received at home in the circumstances shown in the benefits table on page 9.
	✗	Treatment received at a hospice.
What cover do I have for diagnostic procedures?	✓	Consultations with a specialist, diagnostic tests ordered by a specialist , CT, MRI and PET scans and surgical procedures , subject to any out-patient benefit limits.
	✗	Genetic screening required to establish a genetic predisposition to certain forms of cancer .

Summary of Cancer cover for Ideal Range

	Cover	
What cover do I have for surgical treatment?	✓	Surgical procedures for the treatment or diagnosis of cancer , as shown on page 17 when that treatment as been established as being effective.
	Ideal 6 and Ideal 6 Choice	At the time of going to print the NHS was commonly providing treatment of cancer within six weeks and therefore it is unlikely that there will be cover on this policy for such surgical treatment .
	✗	Experimental or unproven surgery. Please refer to Section 6 on page 15 for further information. CL1 If you have cover level one, please refer to Section 11 for details of your extended cover for experimental surgical procedures.
Am I covered for preventive treatment?	✗	Preventive treatment , for example: <ul style="list-style-type: none"> • Screening undertaken as a preventive measure where there are no symptoms of cancer. For example, if you receive genetic screening, the result of which shows a genetic predisposition to breast cancer, you would not be covered for the screening or a prophylactic mastectomy to prevent the development of breast cancer in the future. • Vaccines to prevent the development or recurrence of cancer, for example vaccinations for the prevention of cervical cancer.
What cover do I have for drug therapy?	✓	Drug treatment of cancer (such as chemotherapy drugs, hormone therapies and biological therapies) where the drug has been licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and is used within the terms of that licence.
	✓	There are some drug treatments for cancer that are typically given for prolonged periods of time. Such prolonged treatment normally falls outside benefit. However in the case of treatment of cancer we make an exception (subject to the limits detailed below) for chemotherapy drugs and biological therapies such as trastuzumab (Herceptin) and bevacizumab (Avastin). The cover provided by this policy for such prolonged cancer drug treatment is payable once per course of cancer treatment . By 'course of cancer treatment ' we mean from diagnosis of a primary or secondary cancer (whichever occurs first) through to the final surgery, radiotherapy or chemotherapy for that primary or secondary cancer (whichever occurs last).

continued overleaf

Summary of Cancer cover for Ideal Range

	Cover	
	Cover level two	<p>These drug treatments will be covered for up to:</p> <ul style="list-style-type: none"> • one year of such treatment; or • the period of the drug licence whichever is the shorter. <p>The time limit starts from when you first started receiving that drug, however it may have been funded.</p> <p>In any event, these drugs will only be eligible for benefit when they are used within the terms of their licence and in circumstances where they are proven to be effective treatments.</p> <p>Please note: changes in drug licensing mean that cancer drug treatments covered under this policy will change from time to time. For further information on licensed cancer treatment please contact our team of Personal Advisers.</p>
	Cover level one	<p>CL1 If you have cover level one, please refer to page 34 for details of your extended cover for drug treatments for cancer that are needed for a prolonged period of time.</p>
	x	<p>Except for the cover provided for chemotherapy drugs and biological therapies previously described there is no cover for drug treatment given to prevent a recurrence of cancer, for the maintenance of remission or where its use is continuing without a clear end date. Such ongoing treatments are not eligible although, if they are given by injection, for example goserelin (Zoladex), we would pay for up to three months to allow the treatment to be established.</p>
	x	<p>Out-patient drugs and drugs prescribed by your GP. For example, hormone therapy tablets (such as Tamoxifen) are out-patient drugs and therefore are not covered by our policies.</p>
Am I covered for radiotherapy?	✓	Radiotherapy, including when used to relieve pain.
Am I covered for terminal care?	x	There is no cover for terminal care, wherever carried out.
Am I covered for monitoring?	✓	Follow up consultations and reviews of cancer will be covered for 10 years from your last surgery, chemotherapy or radiotherapy for that cancer , subject to any out-patient benefit limits.
Am I covered for bone marrow or stem cell treatment?	✓	Stem cell treatment and bone marrow treatment , including the reasonable costs incurred for a live donor to donate bone marrow or stem cells as shown on page 17, section 6.3(b).
	x	Any related administration costs (such as, but not limited to, transport costs and the cost of a donor search).

8 Where you are covered for treatment

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

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

The **Directory of Hospitals** is available on **our** website: www.axapphealthcare.co.uk or by contacting **our** Personal Advisory Team.

Please note:

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

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

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

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

Cover level two members: If **you** have **in-patient** or **day-patient treatment** in any private hospital which **we** do not list in the **Directory of Hospitals** then **we** will pay **you** only a small cash benefit shown in the core **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 core **benefits table**.

CL1 If you have cover level one there is extended cover for **treatment** received at a hospital outside of the **Directory of Hospitals**, please refer to Section 11 for details.

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

Your **policy** includes cover for computerised tomography (CT), magnetic resonance imaging (MRI) scans and positron emission tomography (PET). If **you** require CT, MRI or PET **we** will make full payment, or set the charges against any excess **you** may have, if **you** use a **scanning centre** listed in the **Directory of Hospitals**.

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

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

Cover level two members: If you use a **scanning centre** that is not listed in the **Directory of Hospitals**, then we will only pay the cash benefit shown in the core **benefits table**.

CL1 If you have cover level one there is extended cover for **treatment** at a **scanning centre** or **facility** outside of the **Directory of Hospitals**, please refer to Section 11 for details.

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

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

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

CL1 If you have cover level one there is extended cover for **treatment** at a **hospital** or **day-patient** unit outside of the **Directory of Hospitals**, please refer to Section 11 for details.

Please note:

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

8.1 We pay for eligible:

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

8.2 What we do not pay for:

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

9 Who we pay for treatment

Your **policy** can provide benefit for **eligible treatment** provided by **specialists, complementary practitioners and clinical practitioners**.

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

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

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

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

We will pay for charges for treatment from:	Specialists*	Clinical practitioners	Complementary practitioners	Physiotherapists
If you are referred by your GP	✓	✗	✓ Please see limits below†	✓ Please see limits below†
If you are referred by a specialist	✓	✓	✓	✓
If you are referred by your dentist	✓	✗	✓	✗

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

†**We** will pay up to an overall maximum of 10 sessions of **treatment** a **year** with a physiotherapist and/or a **complementary practitioner**.

CL1 †If **you** have cover level one there is extended cover for up to an overall maximum of 20 sessions of **treatment** a **year** with a physiotherapist and/or a **complementary practitioner**. Please refer to Section 11 for details of your extended cover for physiotherapy and **complementary practitioner treatment**.

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 treatment charges be met in full?

We publish a document called the 'schedule of procedures and fees' which sets out what we will pay **specialists, complementary practitioners and clinical practitioners**, for the services they provide to **our** customers. We will pay **eligible** fees in full when a **specialist, complementary practitioner or clinical practitioner** charges up to the level shown within the schedule of procedures and fees. This is available on **our** website: www.axapphealthcare.co.uk or by contacting **our** Personal Advisory Team.

We strongly advise that **you** call **us** before **you** receive **treatment**, to confirm whether **we** will pay the **treatment** charges in full for the person **you** are planning to see. If **we** will not pay the fee in full **we** will tell **you** how much **we** will pay towards the cost of your **treatment**, from the schedule of procedures and fees. We have identified **specialists, complementary practitioners and clinical practitioners** whose fees **we** pay in full, and these make up the majority of all **specialists** and practitioners.

CL1 If you have cover level one we will pay the **eligible** charges made by physiotherapists in full up to the monetary limit in the core **benefits table**. Please refer to Section 11 for details of your extended cover for physiotherapy and **complementary practitioner treatment**.

What if an anaesthetist becomes involved in my treatment?

Before receiving surgical **treatment** it is advisable to establish which anaesthetist your **specialist** intends to use. This will mean **we** can tell **you** if that anaesthetist is one who **we** pay in full or, if this is not the case, what fee **we** will pay (as set out in the schedule of procedures and fees). However, if **you** don't know when **you** call **us** which anaesthetist your **specialist** intends to use **we** will make every effort to notify **you** whether they commonly work with an anaesthetist who **we** do not pay in full.

9.1 We pay for eligible:

- (a) **Treatment** charges made at the level set out in **our** schedule of procedures and fees, or at the amount charged if lower than that level.

9.2 What we do not pay for:

- (a) Charges made by a **specialist** or **complementary practitioner** when **you** have been referred by a member of your family, or if that **specialist** or **complementary practitioner** is a member of your family.
- (b) **Treatment** charges made when they are above the level set out in **our** schedule of procedures and fees.
- (c) **Treatment** charges made by a **specialist, complementary practitioner** or **clinical practitioner** who **we** have identified to **you** as someone whose fees **we** will pay in full if, without **our** prior agreement, they charge significantly more than their usual amount for **treatment**.
- (d) Charges for general chiropody or foot care even if this is carried out by a surgical podiatrist.
- (e) Any charges made for written reports or any other administrative costs.

10 Overseas assistance services

What assistance is available if I fall ill overseas?

Be aware:

CL1 Under normal circumstances there is no cover on the **policy** for **treatment** received outside the **United Kingdom**. However, if **you** have cover level one **you** have extended cover for pre-planned **treatment** which takes place outside the **United Kingdom**, full details of which can be found on page 35. **We** strongly advise **you** to take out travel insurance when travelling abroad.

However, should **you** fall ill abroad **you** do have access to an overseas medical assistance line. This service is provided by an international assistance company on **our** behalf. The overseas medical assistance line is manned around the clock to provide help and assistance in any part of the world. They will normally give immediate advice and can arrange to put **you** in touch with an English-speaking doctor. That doctor will help to arrange **treatment** locally or, if **you** have already commenced **treatment**, will ensure that existing arrangements are satisfactory. Simply call the emergency control centre on +44(0) 1892 513 999 to alert the international assistance company who will help **you** on **our** behalf. Please note in this situation any costs incurred for **treatment** would not be **eligible** for benefit.

This **policy** also provides an emergency **evacuation or repatriation service** should **you** be injured, or become ill suddenly, and require emergency immediate **in-patient treatment**, subject to the restrictions set out in this section of the **policy** document. The exclusions in other sections of this document do not apply to the **evacuation or repatriation service** but will apply to **treatment** on your return to the **United Kingdom**.

If **you** need the **evacuation or repatriation service** **you** must contact the emergency control centre on +44(0) 1892 513 999 so that immediate help or advice can be given over the phone. Arrangements may then be made for an **appointed doctor** to see **you**. If the **appointed doctor** establishes that the hospitals locally are inadequate, or the appropriate **treatment** is unavailable locally then they will arrange to move **you** or bring **you** back to the **United Kingdom**. If an **appointed doctor** thinks there is a medical need then the **evacuation or repatriation service** will be carried out under medical supervision.

The full rules relating to the **evacuation or repatriation service** can be found under 10.3 and 10.4.

10.1 The evacuation or repatriation service will provide:

- (a) An **evacuation or repatriation service** as set out in 10.3 and 10.4 and immediate emergency **in-patient treatment** received while travelling abroad, when it immediately precedes or immediately follows an evacuation or repatriation **we** have arranged for **you**.

In these circumstances **we** will pay benefits in pounds sterling. This means **we** will need to convert the expenditure into sterling and **we** use the exchange rate published in the Financial Times Guide to World Currencies current when **we** assess the claim.

Please note:

We cannot settle the bill direct for **treatment** received abroad.

10.2 What we do not pay for:

- (a) Any **treatment** received abroad that does not immediately precede or immediately follow an evacuation or repatriation **we** have arranged for **you**.
- (b) Claims on this **policy** if **you** live outside the **United Kingdom** or if **you** have travelled outside the **United Kingdom** to get **treatment** (whether or not that was the only reason) or travelled against medical advice (including the published advice of the Chief Medical Officer of the Department of Health of England).

Specific terms relating to the overseas evacuation or repatriation service

10.3 The overseas evacuation or repatriation service is available to provide the following services when the arrangements are made by us:

- (a) Transferring **you** by air ambulance, regular airline or any other method of transport **we** consider appropriate. **We** will decide the method of transport and the date and time.
- (b) Cover for the reasonable and necessary transport and additional accommodation costs for another person, who must be 18 or over, to accompany **you** if **you** are under 18 (or in other cases where **we** believe that your **medical condition** makes it appropriate) while **you** are being moved.
- (c) Cover for the reasonable additional travelling and accommodation costs, incurred in returning to the **United Kingdom** any **family members** covered by an AXA PPP healthcare policy who are accompanying **you** on the overseas journey.
- (d) Bringing your body back to a port or airport in the **United Kingdom** if **you** die abroad.

10.4 The overseas **evacuation or repatriation service** will not be available for the following:

- (a) Any **medical condition** which does not prevent **you** from continuing to travel or work and which does not need immediate emergency **in-patient treatment**.
 - (b) Any costs incurred which arise from or are directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide.
 - (c) Any costs incurred which arise from, or are in any way connected with, alcohol abuse, drug abuse or substance abuse.
 - (d) Any costs incurred as a result of engaging in any sports or activity as a professional or taking part in base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hangliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste.
 - (e) Moving **you** from a ship, oil-rig platform or similar off-shore location.
 - (f) Any costs that **we** do not approve beforehand or costs incurred where **we** have not been told about the accident or illness for which **you** need the overseas **evacuation or repatriation service** within 30 days of it happening (unless this was not reasonably possible).
 - (g) **Treatment** costs other than for the necessary **treatment** administered by the international assistance company appointed by **us** whilst they are moving **you** and immediate emergency **in-patient treatment** received while travelling abroad when it immediately precedes or immediately follows an evacuation or repatriation **we** have arranged for **you**.
 - (h) Any unused portion of your travel ticket, and that of any accompanying person, will immediately become **our** property and **you** must give it to **us**.
 - (i) Any costs incurred as a result of nuclear, biological 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.
 - (j) Any costs incurred if at the time of travel **you** are travelling to a country or area that the UK Foreign and Commonwealth Office lists as a place which they either advise against:
 - all travel to; or
 - all travel on holiday or non essential business.
- This exclusion applies whatever your reason for travel.

10.5 We will not be liable in respect of the overseas **evacuation or repatriation service** for:

- (a) Any failure to provide the overseas **evacuation or repatriation service** or for any delays in providing it, unless the failure or delay is caused by **our** negligence (including that of the international assistance company **we** have appointed to act for **us**), or of agents appointed by either party.
- (b) Failure or delay in providing the overseas **evacuation or repatriation service** if:
 - by law the overseas **evacuation or repatriation service** cannot be provided in the country in which it is needed; or
 - the failure or delay is caused by any reason beyond **our** control including, but not limited to, strikes and flight conditions.
- (c) Injury or death caused while **you** are being moved unless it is caused by **our** negligence or the negligence of anyone acting on **our** behalf.

11 Cover level one – Extended benefits

If **you** have cover level one this will be shown on your membership statement. As a cover level one member, in addition to the benefits shown in sections 1–10 of this handbook, **you** also have extended cover for the benefits detailed below.

Should **you** have any queries about your **policy**, or need to pre-authorise **treatment** please contact **our** team of Personal Advisers on the number shown in this membership handbook.

Additional cover for physiotherapy and complementary practitioner treatment

The 'Who we pay for treatment' section contains information on the standard cover for physiotherapy and **complementary practitioner treatment**.

As **you** have cover level one, **you** have cover for an additional ten sessions of GP referred **treatment** a year with a physiotherapist and/or a **complementary practitioner**, meaning **you** have cover for up to 20 sessions a year.

Additionally, the rules regarding payment of fees up to the level set out in the schedule of procedures and fees will continue to apply to other types of **clinical practitioner**.

Additional cover for cancer treatment

The 'Recurrent, continuing and long-term treatment' section contains information on the standard cover for **cancer treatment**.

As **you** have cover level one, in addition to being able to receive your **cancer treatment** at a private hospital, **day-patient unit** or **scanning centre** not listed in the **Directory of Hospitals** as shown overleaf, **you** also have extended cover for chemotherapy drugs and biological therapies such as trastuzumab (Herceptin) and bevacizumab (Avastin) **treatments** that are typically given for prolonged periods of time. These drug **treatments** will be covered for an additional two years and this time limit starts from when **you** first start receiving the drug **treatment** from **us**. So, if **you** choose to start your drug **treatment** on the NHS and later choose to continue that **treatment** privately, the NHS **treatment** will not count towards your total three years cover.

These drugs will be **eligible** for benefit provided they are used within the terms of their licence.

Additional cover for treatment received outside of the Directory of Hospitals

The 'Where you are covered for treatment' section contains information on the standard terms which apply to where **you** are **eligible** to receive **treatment**.

As **you** have cover level one, **you** have extended cover for **treatment** received at any hospital, **day-patient unit**, **out-patient facility** or **scanning centre** in the **United Kingdom** and we will pay

their charges up to the normal daily rates published and charged by the hospital, **day-patient unit, out-patient facility or scanning centre.**

Additional cover for experimental and unproven treatment

The 'Your cover for certain types of treatment' section contains information on the standard terms which apply to new or experimental **treatments.**

As **you** have cover level one **you** have extended cover to include experimental and unproven surgical procedures. This means **you** are covered for any surgical procedures which are not listed in the schedule of procedures when **we** agree the fee for that surgical procedure before it is received.

You are not covered for any complications that arise as the result of authorised experimental and unproven surgical procedures. **We** recommend that **you** discuss potential complications and their cost with your **specialist** prior to receiving the surgical procedure as **you** will be liable for the cost, which may be significant.

Important information: **We** will pay for the cost of an experimental surgical procedure up to the cost of the equivalent non-experimental **surgical procedure** in the **UK.** If there is no equivalent **surgical procedure** listed in the schedule of procedures then no cover will be available for the experimental or unproven surgical procedure.

Additional cover for treatment received overseas

As **you** have cover level one **you** have a higher annual limit of £100,000 for emergency **in-patient treatment** abroad which is needed prior to an evacuation or repatriation covered by this **policy,** as shown in the **benefits table.**

Additionally, **you** also have cover for **eligible treatment** received outside of the **United Kingdom,** subject to all other benefit limitations and exclusions on your **policy.**

This means that should **you** need **eligible treatment** and want to receive this outside of the **United Kingdom,** provided the fee has been agreed by **us** prior to the overseas journey and it is carried out by a **medical practitioner,** **you** will be covered up to the cost of equivalent **treatment** had it been received in the **United Kingdom.** However, this **policy** does not provide cover for complications which arise as a result of **treatment** received outside of the **United Kingdom,** or cover for evacuation or repatriation if **you** travel abroad for planned **treatment.** **We** recommend that **you** discuss potential complications and their costs with your **medical practitioner** prior to travel, as **you** will be liable for the cost, which may be significant.

Important information: other than the limited cover provided by the overseas evacuation and repatriation cover, the overseas cover provided under cover level one is not designed to provide cover for unplanned **treatment** received abroad. **We** strongly advise **you** to take out travel insurance when travelling abroad to cover **you** for unplanned **treatment** which is not covered by this **policy.**

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

12 Health at Hand

How could Health at Hand help me?

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

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

Please note:

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

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

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

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

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

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

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

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

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

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

Health at Hand – 0800 003 004

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

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

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

13 Additional information

When can I add other members or change my cover?

You can apply to add a **family member** to your **policy** at any time. Also, **you** may be able to change your cover at your renewal. Call **us** so **we** can discuss the options open to **you** and send **you** any relevant forms to complete. **You** must keep **us** fully informed of any changes which take place between sending **us** any form and receiving **our** written confirmation that **we** have made the change.

Can I add my new baby to my policy?

You can apply to add newborn babies (who are born to the **policyholder** or the **policyholder's** partner) to the **policy** from their date of birth. This can normally be done without filling out details of their medical history provided **you** add them within three months of their date of birth. However, **we** will require details of the baby's medical history if the baby has been adopted or was born as the result of any method of assisted conception. In such circumstances **we** reserve the right to apply particular restrictions to the cover **we** will offer and **we** will notify **you** of those terms as soon as reasonably possible. This may limit your baby's cover for existing **medical conditions**. This would mean that your baby will not be covered for **treatment** carried out for **medical conditions** which existed prior to joining, such as **treatment** in a Special Care Baby Unit and **you** will be liable for these costs.

Can I stay on 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, as **we** have a range of international policies that have more appropriate benefits for anyone living abroad.

Can I cancel my policy?

You have a 14 day cooling off period when **you** join and at each renewal. Please see section 14.1(g) 'Your rights and responsibilities'.

How can I pay my premium?

At the start of each **policy year** **we** will calculate your new premium and let **you** know how much it is. **We** offer a choice of paying monthly, quarterly or annual premiums by Direct Debit. Alternatively **you** may pay quarterly or annually by cheque.

If **you** pay by Direct Debit **we** will collect the first premium when your **policy** starts and subsequent premiums when they fall due.

Please note:

In some circumstances **you** may have joined on the basis that all premiums will be collected by Direct Debit; if that is the case **you** will not be able to change to a different payment method. Please contact **us** if **you** are in any doubt about your payment options.

Be aware:

Important – **you** must pay your premium when it is due. If **you** do not **we** will cancel your **policy** and will not pay for any **treatment** or benefit entitlement arising after the date that the premium became due.

Why do you make changes to my premiums?

We make every effort to maintain premiums at as low a level as possible, without compromising the range and quality of the cover provided. **We** review premiums each **year** to take account of a range of statistical factors. Typically the cost of premiums has increased at a level higher than the Retail Price Index (RPI). **You** will receive reasonable notice of any changes in premium. Your premium will also include the amount of any insurance premium tax or other taxes or levies which are payable by law in respect of your **policy**.

How can an excess help to reduce my premium?

Choosing an excess on your **policy** may help to reduce your premiums. If **you** would like to find out how to add an excess or change your existing excess level please call **us**.

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

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

- An excess is the amount of money **you** must contribute towards the cost of any **eligible treatment** each **policy year**.
- The excess applies to each person covered by the **policy** in each **policy year**.
- The excess is deducted from any **eligible treatment** costs **you** incur.
- When a claim is made that involves an excess, **we** will pay the claim after **we** have deducted the excess amount.
- The excess is a single deduction that is made regardless of the number of individual **medical conditions** claimed for in that **policy year**.
- Should **treatment** continue beyond your **policy's** renewal date then **we** will apply the excess:
 1. Once against the costs incurred before this date, and;
 2. Again against the costs incurred on or after the renewal date.

We will do this irrespective of whether the costs relate to **treatment** for the same **medical condition**.
- **We** will not apply the excess against medical costs for **treatment** that your **policy** does not cover.

Please see the following examples (overleaf).

If you have an excess, here are two examples of how the excess operates:

Example 1 – £200 excess	These policies have a benefit limit of £900 (for each person each year) for out-patient consultations, diagnostic tests, complementary practitioners' and clinical practitioners' charges.
One	You develop a medical problem and require £400 of eligible diagnostic tests – your first claim for that policy year.
Two	The £200 excess charge is applied.
Three	We pay £200 towards the £400 cost of out-patient treatment , while you pay the £200 excess.
Four	This £400 total claim reduces your £900 benefit limit for out-patient consultations, diagnostic tests, complementary practitioners' and clinical practitioners' charges to £500.
Then...	Later in the same policy year , you suffer a different medical condition , incurring costs of £550 for eligible out-patient consultations and diagnostic tests – £50 more than the policy's remaining £500 benefit limit.
So...	We pay £500 towards the cost of treatment , and you pay the £50 shortfall.

If the first claim relates to a benefit with a monetary limit, then **we** will reduce the monetary limit by the total cost incurred before **we** apply the excess. If **you** have a high excess then **you** may find that, within a reasonable period, **you** will reach or exceed the limit of those benefits that have monetary limits. Example 2 demonstrates this.

Example 2 – £200 excess	These policies have a benefit limit of £900 (for each person each year) for out-patient consultations, diagnostic tests, complementary practitioners' and clinical practitioners' charges.
One	You require £1,000 of eligible diagnostic tests but the plan limit is £900.
Two	So we pay £900 for treatment – less the £200 excess – giving a total of £700.
Three	You pay the remaining £100 not covered by the policy plus the £200 excess making a total of £300.
So...	Leaving no further benefit for out-patient consultations, diagnostic tests, complementary practitioners' and clinical practitioners' charges for the rest of the policy year.

14 Complaint and regulatory information

What should I do if I have reason to complain?

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

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

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

Step one

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

Step two

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

Customer Relations Executive

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

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

Step three

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

The Operations Director

AXA PPP healthcare, PPP House, Vale Road, Tunbridge Wells TN1 1BJ

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

Step four

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

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

Telephone: 0845 080 1800

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

Website: www.financial-ombudsman.org.uk

The Ombudsman will review complaints about:

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

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

The Ombudsman will also not usually review a complaint where:

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

None of these procedures affect your legal rights.

What regulatory protection do I have?

The Financial Services Authority (FSA)

AXA PPP healthcare is authorised and regulated by the Financial Services Authority (FSA).

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

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

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

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

The Financial Services Compensation Scheme (FSCS)

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

The scheme may assist by providing financial assistance to the insurer concerned, by transferring policies to another insurer, or by paying compensation to eligible policyholders.

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

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

How is my personal data protected?

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

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

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

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

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

If **you** have agreed **we**, and any AXA Group companies **we** named at that time, may use the information **you** have provided to **us** to contact **you** by post, telephone or electronically with details of other products and services. With your agreement **we** may also share some of your details with other 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** change your mind please contact **our** team of Personal Advisers or write to **us** at the address on the back of this handbook otherwise **we** will assume that, for the time being, **you** are happy to be contacted in this way.

Legal rights and responsibilities

14.1 Your rights and responsibilities

- (a) Your **policy** is for one **year**. Prior to the end of any **policy year** we will write to the **policyholder** to advise on what terms the **policy** will continue, provided the **policy** you are on is still available. If we do not hear from the **policyholder** in response we will renew your **policy** on the new terms. Where you have opted to pay premiums by Direct Debit or other payment method, we may continue to collect premiums by such method for the new **policy year**. Please note that if we do not receive your premium, you will not be covered. If the **policy** you were on is no longer available we will do our best to offer you cover on an alternative policy.
- (b) You must make sure that whenever you are required to give us any information, all the information you give us is sufficiently true, accurate and complete so as to give us a fair presentation of the risk we are taking on. If we discover later it is not, then we can cancel the **policy** or apply different terms of cover in line with the terms we would have applied had the information been presented to us fairly in the first place.
- (c) 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.
- (d) You must write and tell us if you change your address.
- (e) 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**.
- (f) You must pay your premium when it is due.
- (g) The **policyholder** may cancel this **policy** by contacting us during the 14 day cooling off period. The 14 day cooling off period commences on the day that the contract is concluded or the day that full policy terms and conditions are received, whichever is the later. The 14 day cooling off period also applies from each renewal date. If the **policy** is cancelled during the 14 day cooling off period we will return any premium paid for the **policy** providing no claims have been made on the **policy** in relation to the period of cover before cancellation (being no more than 14 days' cover).

If you incur **eligible** claims costs within that period of cover we reserve the right to require the **policyholder** to pay for the services we have actually provided in connection with the **policy** to the extent permitted by law and any return of premium is subject to this. If the **policyholder** does not cancel the **policy** during the cancellation period the **policy** will continue on the terms described in this handbook for the remainder of the **policy year**.

continued overleaf

14.2 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** which **we** reasonably consider to be fundamental, **we** may (subject to 14.2(e)) do one or more of the following:
- refuse to make any benefit payment or if **we** have already paid benefits **we** can recover from **you** any loss to **us** caused by the break;
 - refuse to renew your **policy**;
 - impose different terms to any cover **we** are prepared to provide;
 - end your **policy** and all cover under it immediately.
- (e) If **you** (or anyone acting on your behalf) make a claim under your **policy** knowing it to be false or fraudulent, **we** can refuse to make benefit payments for that claim and may declare the **policy** void, as if it never existed. If **we** have already paid benefit **we** can recover those sums from **you**. Where **we** have paid a claim later found to be fraudulent, (whether in whole, or in part), **we** will be able to recover those sums from **you**.
- (f) **We** can change all or any part of the **policy** from any renewal date. **We** will give **you** reasonable notice of changes to your **policy** terms.
- (g) This **policy** is written in English and all other information and communications to **you** relating to this **policy** will also be in English.

15 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.

Please note: some of these words and phrases may not be applicable to your chosen plan.

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

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

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

appointed doctor – a medical practitioner chosen by **us** to advise **us** on your **medical condition** and need for the **evacuation or repatriation service**.

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

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

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

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

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

When such persons provide such services to **you** as part of your **in-patient** or **day-patient treatment** those services will form part of the **private hospital** charges.

The professions concerned are dieticians, **nurses**, orthoptists, physiotherapists, psychologists, psychotherapists and speech therapists.

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

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

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

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

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

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

Directory of Hospitals – a document **we** publish on **our** website: www.axapphealthcare.co.uk 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**.

evacuation or repatriation service – moving **you** to another hospital which has the necessary medical facilities either in the country where **you** are taken ill or in another nearby country (evacuation) or bringing **you** back to the **United Kingdom** (repatriation).

The service includes immediate emergency **in-patient treatment** received while travelling abroad, when it immediately precedes or immediately follows an evacuation or repatriation **we** have arranged for **you**, and any necessary **treatment** administered by the international assistance company appointed by **us** whilst they are moving **you**.

facility – a **private hospital** or a centre with which **we** have an agreement to provide a specific range of medical services and which is listed in the **Directory of Hospitals**.

In some circumstances **treatment** may be carried out at an establishment which provides **treatment** under an arrangement with a **facility** listed in the **Directory of Hospitals**.

family member – (1) the **policyholder's** current spouse or civil partner or any person (whether or not of the same sex) living permanently in a similar relationship with the **policyholder** and (2) any of their or the **policyholder's** unmarried children.

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 practitioner – a person who has the primary degrees in the practice of medicine and surgery following attendance at a recognised medical school and who is licensed to practice medicine by the relevant licensing authority where the **treatment** is given.

By 'recognised medical school' we mean 'a medical school which is listed in the current World Directory of Medical Schools published by the World Health Organisation'.

Please note: the definition only applies to the additional overseas cover provided under cover level one.

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

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

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**.

Please note: this membership handbook contains the terms and benefits tables for the following products: Ideal, Ideal 6, Ideal Choice, Ideal 6 Choice, and if **you** have a 'Choice' **policy** your **policy** terms will also include an addendum which will detail how your no claims discount works and any other special terms that may apply to your **policy**.

policyholder – the first person named on the **policy** membership statement. If the first person named on the **policy** membership statement is under 18 then we will treat the person who pays the premium as the **policyholder**, in this circumstance the **policyholder** will not be entitled to cover under this **policy**.

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

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

The centres **we** recognise for benefit purposes are listed in the **Directory of Hospitals**.

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

out-patient treatment only:

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

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

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

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

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

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

we/us/our – AXA PPP healthcare.

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

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

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