

Company medical insurance

Membership handbook /

Corporate Health Plan

For employees of Wellcome Trust Sanger Institute



What you need to know

July 2010

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 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 0845 600 2072

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

If your corporate cover ends call 0800 028 2915

If your corporate healthcare cover ends, **you** can continue with **us** on a personal **policy**.

Just call **our** team of advisers on 0800 028 2915 to discuss your options.

We're available to take your call between 8am and 8pm Monday to Friday and between 9am and 1pm on Saturdays.

Health at Hand 0800 003 004

Available: day or night, 365 days a year.

Our health information service. See page 28.

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

Available: day or night, 365 days a **year**.

www.axapphealthcare.co.uk

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 600 2072 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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How can I retain my cover if my corporate healthcare scheme ends?

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

To ensure continuous cover, call **us** on 0800 028 2915 as soon as **you** know **you** will be leaving your **company** scheme. We'll help **you** decide upon the best personal healthcare plan to suit **you**. Please see section 11 for full terms and conditions.

1 Introduction

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

This handbook sets out the terms of your cover. 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 35–37.

Group number: 44555

Enter your membership number.

2 Your cover

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

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

Summary of the Corporate Health Plan

The Corporate Health Plan **policy** offers **you** cover for necessary **treatment** of **medical 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
- **out-patient diagnostic tests**, consultations and **complementary practitioner** and **clinical practitioner** charges (including physiotherapy)
- **treatment** of psychiatric illness.

Be aware:

Your policy will not cover you for:	For more information:
General dental procedures.	Page 10
Routine pregnancy and childbirth.	Pages 12–13
Ongoing, recurrent or long-term treatment of long-term illnesses (usually referred to as ' chronic conditions ').	Pages 14–19
Charges when treatment is received outside of our Directory of Hospitals .	Pages 20–21

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.

There is a **policy** benefit limit of £50,000 per person per **year**.

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

Benefits	Benefit limit (amount payable)
In-patient & day-patient treatment	
1. Private hospital and day-patient unit charges. Including charges for accommodation, diagnostic tests , operating theatre charges, nursing care, drugs and dressings, physiotherapy, and surgical appliances used by the specialist during surgery.	Paid in full within your policy benefit limit at a private hospital or day-patient unit listed in the Directory of Hospitals .
For more information on the above please see: Pages 20–21	
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 .	£100 each day for day-patient treatment . £100 each night for in-patient treatment .
For more information on the above please see: Pages 20–21	
3. Specialists’ fees (surgeons’, anaesthetists’ and physicians’).	No annual maximum within your policy benefit limit.
For more information on the above please see: Pages 22–23	
4. In-patient consultations. Benefit for a consultation with a second specialist arranged by the treating specialist .	No annual maximum within your policy benefit limit.
For more information on the above please see: Pages 22–23	
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.	Paid in full

Benefits	Benefit limit (amount payable)
Out-patient treatment	
6. Surgical procedures.	No annual maximum within your policy benefit limit.
For more information on the above please see:	Pages 22–23
7. Specialist consultations.	No annual maximum within your policy benefit limit.
For more information on the above please see:	Pages 22–23
8. Diagnostic tests on specialist referral.	No annual maximum within your policy benefit limit.
For more information on the above please see:	Pages 22–23
9. Clinical practitioner charges (including physiotherapy).	No annual maximum within your policy benefit limit. However we will only pay for up to an overall maximum of 10 sessions of treatment a year for GP referred physiotherapy and/or complementary practitioner treatment .
10. Complementary practitioner charges.	
For more information on the above please see:	
11. Radiotherapy (the use of radiation to treat cancers) and chemotherapy (the use of drugs to treat cancers).	Paid in full within your policy benefit limit.
For more information on the above please see:	Pages 16–19
12. (i) Computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET). (ii) Out of directory scanning cash benefit. This benefit is payable for using a CT, MRI or PET facility not listed as a scanning centre in the Directory of Hospitals .	Paid in full in a scanning centre listed in the Directory of Hospitals . £100 each visit
For more information on the above please see:	Pages 20–21
Other benefits	
13. Ambulance transport. When you are receiving private in-patient or day-patient treatment and it is medically necessary to use a road ambulance to transport you between a hospital and another medical facility .	Paid in full within your policy benefit limit.
14. Immediate emergency in-patient treatment received while travelling abroad. Benefits 1, 3–5 (including any limits) also apply to treatment needed abroad.	Up to £50,000 a year . <i>continued overleaf.</i>

Benefits	Benefit limit (amount payable)
Other benefits – continued	
15. Overseas evacuation or repatriation service . Evacuation and repatriation costs.	Paid in full within your policy benefit limit.
For more information on the above please see: Pages 24–27	
16. Hospital-at-home. This is for treatment provided at home or another clinically appropriate setting for the administration of intravenous chemotherapy for the treatment of cancer or intravenous antibiotics which would otherwise require you to be admitted for in-patient or day-patient treatment .	Paid in full when treatment : <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.
17. NHS cash benefits. This benefit is paid for each night you receive free treatment under the NHS and only if: (i) you are admitted for in-patient treatment before midnight (ii) the treatment you receive under the NHS would have been eligible for benefit privately under this policy . There is no requirement for private treatment to have preceded any period in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.	£50 a night up to £5,000 a year .
For more information on the above please see: Pages 20–21	
18. Day-patient and out-patient NHS radiotherapy and chemotherapy cash benefit. This benefit is paid for day-patient or out-patient radiotherapy or chemotherapy you receive free under the NHS for the treatment of cancer and only if the treatment you receive under the NHS would have been eligible for benefit privately under this policy .	£50 a day up to £5,000 a year .
For more information on the above please see: Page 16	
19. Health at Hand. Confidential medical information.	Immediate access 24 hours a day, 365 days a year.
For more information on the above please see: Page 28	

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	Can the NHS provide treatment quickly? If yes, ask the GP to arrange an NHS specialist appointment and claim NHS cash benefit of £50 a night for NHS in-patient treatment .
Step Three	If the NHS cannot provide treatment quickly: You need to call us 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 Four	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 patient's declaration and consent form.
Step Five	<ul style="list-style-type: none"> • Sign the patients declaration and consent form and return to us. • Attend the specialist appointment.
Step Six	Send in any outstanding accounts for treatment to AXA PPP healthcare. If you require further treatment contact us to confirm your cover.

Please send any correspondence to:

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

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?

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 call **us** as **you** may be able to claim for the NHS cash benefit shown on the **benefits table** on page 6.

If **you** are taken ill while travelling abroad, please follow the procedure described on pages 24–27.

continued overleaf.

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**. 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
- **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 12.2(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 Your cover for certain types of treatment

Will my policy cover me for preventive treatment?

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

Please note:

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

What other treatments are not covered?

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

5.1 We pay for eligible:

- (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** agree the cost of the **treatment** in writing before it is done (see also 5.2(i)).
- (d) **Treatment** of astigmatism where the astigmatism arises from the surgical replacement of the lens of the eye (see also 5.2(k)).

5.2 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.
- (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.

5.2 continued

- (i) Cosmetic (aesthetic) surgery or **treatment**, or any **treatment** relating to previous cosmetic or reconstructive **treatment**. (See also 5.1(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 5.1(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.

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.

5.3 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 5.4(c)).

5.4 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**.

5.5 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
 - post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
 - miscarriage requiring immediate surgical **treatment**
 - failure to progress in labour.

5.6 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.
- (e) Any **treatment** for a baby born as the result of any method of assisted conception while the baby requires **treatment** in a Special Care Baby Unit or requires paediatric intensive care.

6 Recurrent, continuing and long-term treatment

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

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

We define a **chronic condition** in the glossary on page 35 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 16.

6.1 We pay for eligible:

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

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

6.2 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.

continued overleaf.

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**.

Benefit for **in-patient treatment** of psychiatric illness is limited to 28 days a **year**.

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**.

6.3 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.

6.4 What we do not pay for:

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

Will my policy cover me for cancer treatment?

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.

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.

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 6, when **you** receive **eligible day-patient** or **out-patient** radiotherapy or chemotherapy **treatment** or **eligible in-patient treatment**.

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 4–6.

Summary of Cancer cover for Corporate Health Plan

	Cover	
Where am I covered for treatment?	✓	Treatment of cancer at a private hospital, day-patient unit or scanning centre listed in our Directory of Hospitals .
	✗	Charges made for the treatment of cancer at a private hospital, day-patient unit or scanning centre not listed in the Directory of Hospitals .
	✓	Intravenous chemotherapy received at home in the circumstances shown on the benefits table on page 6.
	✗	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 pre-disposition to certain forms of cancer .
What cover do I have for surgical treatment?	✓	Surgical procedures for the treatment or diagnosis of cancer , as shown on page 11 when that treatment has been established as being effective.
	✗	Experimental or unproven surgery. Please refer to the 'Your cover for certain types of treatment' section on page 11 for further information.
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.

continued overleaf.

Summary of Cancer cover for Corporate Health Plan (continued)

	Cover	
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.
	✓	<p>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).</p> <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 <p>whichever is the shorter.</p> <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>

Summary of Cancer cover for Corporate Health Plan (continued)

	Cover	
	x	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.
	x	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.
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 11, section 5.3(b).
	x	Any related administration costs (such as, but not limited to, transport costs and the cost of a donor search).

7 Where you are covered for treatment

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

The **Directory of Hospitals** lists the hospitals and **day-patient units** in the **United Kingdom** for which **we** provide cover. **We** have chosen 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?

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 **benefits table**. **You** will be entirely responsible for paying the hospital bills.

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

Which scanning centres 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**. 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 **benefits table**.

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).

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

We will pay for those oral **surgical procedures** detailed in 5.1(b) when your dentist refers you directly to a **facility** with which we have an agreement to provide a range of oral **surgical procedures**.

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

Please note:

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

7.1 We pay for eligible:

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

7.2 What we do not pay for:

- (a) Any charges from health spas, 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 7.1(a).

8 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**.

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.

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.

8.1 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.

8.2 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.

9 Emergency treatment abroad

What overseas cover do I have on my policy?

Your **policy** has been designed primarily to provide cover for medical **treatment** received within the **United Kingdom**. However should **you** be taken ill abroad and require immediate emergency **in-patient treatment** there is some medical cover available, subject to the **policy** terms and conditions for **treatment** received in the **United Kingdom**. However this **policy** does not provide comprehensive travel cover, and **we** strongly advise **you** to take out full travel insurance when travelling abroad.

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

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

What should I do if I require treatment abroad?

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. The emergency control centre 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. Please note, however, that any costs incurred for **treatment** would not be **eligible** for benefit unless **you** require emergency **in-patient treatment**.

Can I be repatriated to the United Kingdom?

There may be reasons why **you** would prefer to return home for **treatment** which does not involve an emergency admission. In this case **you** will be covered by the benefits of this **policy** on return to the **United Kingdom** and can claim in the usual way. The cost of returning home in these circumstances will be your responsibility.

However should **you** be injured or become ill suddenly and need immediate emergency **in-patient treatment** then the **evacuation or repatriation service** will become available to **you**. The exclusions in other parts of this document do not apply to the **evacuation or repatriation service** but will apply to **treatment** in the **United Kingdom**. If **you** need the **evacuation or repatriation service** **you** must contact the emergency control centre so that immediate help or advice can be given over the phone. Arrangements may then be made for an **appointed doctor** to see **you** and to move **you** or bring **you** back to the **United Kingdom** if necessary. If an **appointed doctor** thinks it is necessary 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 9.3 and 9.4.

9.1 We pay for eligible:

- (a) Immediate emergency **in-patient treatment** received while travelling abroad. If **you** receive **treatment** abroad then **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 that **we** cannot settle the bill direct for **treatment** received abroad.

9.2 What we do not pay for:

- (a) Any **treatment** received abroad that does not require immediate emergency **in-patient treatment**.
- (b) Any **treatment** received abroad which would not have been **eligible** for cover had it been carried out within the **United Kingdom**.
- (c) 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

9.3 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, by a regular airline or by any other method of transport **we** consider appropriate. **We** will decide the method of transport and the date and time.
- (b) Cover for 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.

continued overleaf.

9.4 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**.
- (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 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.

9.5 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.

10 Health at Hand

How could Health at Hand help me?

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

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

Please note:

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

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

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

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

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

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

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

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

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

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

Health at Hand – 0800 003 004

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

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

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

11 Additional information

When can I add other members?

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

Please ask your Human Resource Department for details. There is no limit to the number of children that are covered, but to be **eligible** children must be aged 21 or under 25 if unmarried and living at home.

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

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

You'll find transferring from a **company** scheme to an AXA PPP healthcare personal plan within the **policy year** is quick, easy and trouble free. Join within three months of leaving and we will guarantee to cover **you**. There will be no application form to fill in and no medical examination and we will also cover **you** without additional medical underwriting if **you** no longer qualify to be covered under the **company** scheme and are transferring to a plan with comparable benefits and restrictions. Your new policy will start on the day your **company** cover ends. Please remember that your entitlement to benefits under your personal policy will be subject to the terms and conditions of the product **you** choose and the level of benefits may differ from those on your corporate **policy**.

To ensure continuous cover, call us on 0800 028 2915 as soon as **you** know **you** will be leaving your **company** scheme. We'll help **you** decide upon the best personal healthcare plan to suit **you**.

Can I add my new baby to my policy?

You can apply to add newborn babies (who are born to the **policyholder** or the **policyholder's** partner) to the **policy** from their date of birth. This can normally be done without filling out details of their medical history, provided **you** add them within three months of their date of birth.

However, if the baby was born as the result of any method of assisted conception there will be no cover for any **treatment** while the baby requires **treatment** in a Special Care Baby Unit or paediatric intensive care and **you** will be liable for these costs.

Will I have to pay income tax on the premiums?

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

12 Complaint and regulatory information

What should I do if I have reason to complain?

We aim to provide you with courteous, efficient service.

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

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

Step one

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

Step two

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

AXA PPP healthcare

Phillips House

Crescent Road

Tunbridge Wells TN1 2PL

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

Step three

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

The Operations Director

AXA PPP healthcare

PPP House

Vale Road

Tunbridge Wells TN1 1BJ

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

Step four

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

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

Telephone: 0845 080 1800

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

Website: www.financial-ombudsman.org.uk

The Ombudsman will review complaints about:

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

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

The Ombudsman will also not usually review a complaint where:

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

None of these procedures affect your legal rights.

What regulatory protection do I have?

The Financial Services Authority (FSA)

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

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

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

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

The Financial Services Compensation Scheme (FSCS)

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

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

How is my personal data protected?

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

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.

We may share details of the value and types of claims with the **policyholder's company** and any intermediaries they authorise, whilst respecting every person's right to medical confidentiality. This is to enable them to assess the value and effectiveness of the cover and **our** services.

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

12.1 Your rights and responsibilities

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

12.2 AXA PPP healthcare's rights and responsibilities

- (a) **We** will tell the **policyholder** in writing the date the **policy** starts and any special terms which apply to it.
- (b) **We** can refuse to add a **family member** to the **policy** and **we** will tell the **policyholder** if **we** do.
- (c) **We** will pay for **eligible** costs incurred during a period for which the premium has been paid.
- (d) If **you** break any of the terms of the **policy** which **we** reasonably consider to be fundamental, **we** may (subject to 12.2(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; and
 - refuse to renew your **policy**; or
 - impose different terms to any cover **we** are prepared to provide; or
 - end your **policy** and all cover under it immediately.
- (e) 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) This **policy** is written in English and all other information and communications to **you** relating to this **policy** will also be in English.

continued overleaf.

12.3 Your company's rights and responsibilities

- (a) Your **policy** is for one **year**. At the end of that time, provided the **policy you** are on is still available, the **company** can renew it on the terms and conditions applicable at that time which **we** shall notify to **you**. **You** will be bound by those terms.
- (b) Only those people described in the **company agreement** can be members of this **policy**.
- (c) All cover ends when the **policyholder** stops working for the **company** or if the **company** decides to end the cover.
- (d) Upon request **we** may provide your **company** or its agent with group claims data in order to monitor the performance of the group scheme as a whole, however in these circumstances **we** will not provide your **company** with personally identifiable medical information about your claims.

13 Glossary

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

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

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

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

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

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

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.

company – your employer.

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

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

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

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

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

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

Directory of Hospitals – a document **we** publish 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. There is no limit to the number of children that are covered, but to be **eligible** children must be aged 21 or under 25 if unmarried and living at home.

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

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

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

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

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

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

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

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

For **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 unless **we** have agreed something different with your **company**.

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

At AXA PPP healthcare we are dedicated to supporting you.

Individual medical insurance

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International medical insurance

Occupational health services

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