Company medical insurance

Membership handbook
VIP, Executive and Business Express

What you need to know

October 2010

AXA PPP HEALTHCARE

redefining / standards

Contacting us

While it is important that **you** read and understand your **policy** handbook, **we** understand that it is often easier to call **us** to obtain information – so **we** have a team of Personal Advisers to help **you**. **You** should always call them on 0800 364 524 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 364 524

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. Please see section 15 for full terms and conditions.

Health at Hand

0800 003 004

Available: day or night, 365 days a year.

Our health information service. See page 44

www.axappphealthcare.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 364 524 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 large print, audio (CD or tape) or Braille format, please contact **us**.

Contents

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 15 for full terms and conditions.

1 Introduction

What is the purpose of this handbook?

This handbook sets out the terms of cover for the VIP, Executive and Business Express 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 page 53.

Please note:

This handbook contains information on the VIP, Executive and Business Express plans.

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 **policy 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 12 'Cover level one - Extended benefits.' This section details how your benefits as a cover level one member have been enhanced.

Please see page 53 for an explanation of words that appear in **bold**

Note for VIP members.

If **you** have a VIP **policy** your **company** may have extended your cover to include a Routine Dental and Optical Upgrade which provides additional benefits for optical and dental care. If **you** have this option it will be shown as 'D&O' in the name of the plan which is included on your membership statement. Further details of this upgrade can be found in the **benefits table** and the 'VIP Routine Dental and Optical Upgrade' section.

Note for VIP and Executive members.

If **you** have a VIP or Executive **policy** your **company** may have extended your cover to include a Psychiatric Upgrade which provides cover for psychiatric **treatment**. If **you** have this option it will be shown as '+ Psych' in the name of the plan which is included on your membership statement. Further details of this upgrade can be found on page 31.

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 the 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 VIP, Executive and Business Express Plans

The VIP, Executive and Business Express policies offer **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
- **diagnostic tests**, **out-patient** consultations and **complementary practitioner** and **clinical practitioner** charges (including physiotherapy): no annual maximum if **you** have VIP; up to £1,200 for cover level one members and up to £1,000 for cover level two members if **you** have Executive; up to £750 for cover level one members and up to £500 for cover level two members if **you** have Business Express
- VIP or Executive members with the Psychiatric Upgrade: **treatment** of psychiatric illness.

Please see page 53 for an explanation of words that appear in **bold**

Be aware:

Your **policy** will not cover **you** for:	For more information:
General dental procedures except for the dental cash benefit available as an upgrade on the VIP **policy**.	Page 26
Routine pregnancy and childbirth.	Page 28
Charges when **treatment** is received outside of **our Directory of Hospitals**.	Page 36
Business Express members and VIP or Executive members who do not have the Psychiatric Upgrade: Psychiatric **treatment**.	Page 31

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 'Who we pay for treatment' section of this handbook for full details.

3 Benefits table for Business Express

The table on the following 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 this table in conjunction with the rest of your handbook.

Please make sure **you** call **our** team of Personal Advisers on 0800 364 524 prior to **treatment** so **we** can confirm the extent of your cover and any limitations that may apply.

Please note:

There is no cover for the **treatment** of psychiatric illness on this **policy**.

Benefits	Cover level two (amount payable)	Cover level one (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 a **private hospital** or **day-patient unit** listed in the **Directory of Hospitals**.	
For more information on the above please see:	Pages 36 - 37	
2. Out of directory cash benefit. This benefit is payable if **you** receive private **in-patient** or **day-patient treatment** at hospital or **day-patient unit** not listed in the **Directory of Hospitals**.	£50 each day for **day-patient treatment**. £50 each night for **in-patient treatment**.	
For more information on the above please see:	Pages 36 - 37	
3. **Specialists'** fees. (Surgeons', anaesthetists' and physicians').	No annual maximum.	
For more information on the above please see:	Pages 38 - 39	
4. **In-patient** consultations. Benefit for a consultation with a second **specialist** arranged by the treating **specialist**.	No annual maximum.	
For more information on the above please see:	Pages 38 - 39	

Please see page 53 for an explanation of words that appear in **bold**

<table>
<tr><td>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.</td><td colspan="2">Paid in full.</td></tr>
<tr><td colspan="3">Out-patient treatment</td></tr>
<tr><td>6. Surgical procedures.</td><td colspan="2">No annual maximum.</td></tr>
<tr><td>For more information on the above please see:</td><td colspan="2">Page 27</td></tr>
<tr><td>7. Specialist consultations.</td><td rowspan="4">These four benefits (7, 8, 9, and 10) have a combined overall limit of £500 a year.
Within the above limit we will pay for up to an overall maximum of ten sessions of treatment a year for GP referred physiotherapy and/or complementary practitioner treatment.</td><td rowspan="4">These four benefits (7, 8, 9, and 10) have a combined overall limit of £750 a year.
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.</td></tr>
<tr><td>8. Diagnostic tests on specialist referral.</td></tr>
<tr><td>9. Clinical practitioner charges (including physiotherapy).</td></tr>
<tr><td>10. Complementary practitioner charges.</td></tr>
<tr><td>For more information on the above please see:</td><td colspan="2">Pages 38 - 39 and CL1 pages 41 - 42</td></tr>
<tr><td>11. Radiotherapy (the use of radiation to treat cancers) and chemotherapy (the use of drugs to treat cancers).</td><td colspan="2">No annual maximum.</td></tr>
<tr><td>For more information on the above please see:</td><td colspan="2">Pages 32 - 35</td></tr>
<tr><td>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.</td><td colspan="2">Paid in full in a scanning centre listed in the Directory of Hospitals.

£50 each visit.</td></tr>
<tr><td>For more information on the above please see:</td><td colspan="2">Pages 36 - 37</td></tr>
</table>

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.
14. NHS cash benefit. This benefit is paid for each night **you** receive free **treatment** under the NHS and only if: • **you** are admitted for **in-patient treatment** before midnight • 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:	Page 36
15. **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:	Pages 29 - 31

16. Childbirth benefit. **We** will pay this cash benefit for each birth occurring after the mother has been covered by this **policy** for 10 consecutive months or more.	£100.	
17. Travel Cover.	Optional.	
For more information on the above please see:	Page 40	
18. Accidental Death Cover.	Not applicable.	£5,000.
For more information on the above please see:	Page 42	
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 44	

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, **day-patient** and **out-patient** NHS radiotherapy and chemotherapy cash benefit or childbirth benefit.

Benefits table for Executive

The table on the following 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 this table in conjunction with the rest of your handbook.

Please make sure **you** call **us** on 0800 364 524 prior to **treatment** so **we** can confirm the extent of your cover and any limitations that may apply.

Benefits	Cover level two (amount payable)	Cover level one (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 at a **private hospital** or **day-patient unit** listed in the **Directory of Hospitals**.	
For more information on the above please see:	Pages 36 - 37	
2. Out of directory cash benefit. This benefit is payable if **you** receive private **in-patient** or **day-patient treatment** at hospital or **day-patient unit** not listed in the **Directory of Hospitals**.	£50 each day for **day-patient treatment**. £50 each night for **in-patient treatment**.	
For more information on the above please see:	Pages 36 - 37	
3. **Specialists'** fees. (Surgeons', anaesthetists' and physicians').	No annual maximum.	
For more information on the above please see:	Pages 38 - 39	
4. **In-patient** consultations. Benefit for a consultation with a second **specialist** arranged by the treating **specialist**.	No annual maximum.	
For more information on the above please see:	Pages 38 - 39	

Please see page 53 for an explanation of words that appear in **bold**

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.	
Out-patient treatment		
6. **Surgical procedures**.	No annual maximum.	
For more information on the above please see:	Page 27	
7. **Specialist** consultations.	These four benefits (7, 8, 9 and 10) have a combined overall limit of £1,000 a **year**. Within the above limit **we** will pay for up to an overall maximum of ten sessions of **treatment** a **year** for GP referred physiotherapy and/or **complementary practitioner treatment**.	These four benefits (7, 8, 9 and 10) have a combined overall limit of £1,200 a **year**. 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**.
8. **Diagnostic tests** on **specialist** referral.		
9. **Clinical practitioner** charges (including physiotherapy).		
10. **Complementary practitioner** charges.		
For more information on the above please see:	Pages 38 - 39 and CL1 pages 41 - 42	
11. 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 32 - 35	
12. (i) Computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET).	Paid in full in a **scanning centre** listed in the **Directory of Hospitals**.	
(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**.	£50 each visit.	
For more information on the above please see:	Pages 36 - 37	

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.
14. 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 otherwise would require **you** to be admitted for **in-patient** or **day-patient treatment**.	Paid in full when **treatment**: • 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.
15. NHS cash benefit. This benefit is paid for each night **you** receive free **treatment** under the NHS and only if: (i) **you** are admitted for **in-patient treatment** before midnight (ii) the **treatment you** receive under the NHS would have been **eligible** for benefit privately under this **policy**. There is no requirement for private **treatment** to have preceded any period in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.	£50 a night up to £5,000 a **year**.
16. **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 32

17. Childbirth benefit. **We** will pay this cash benefit for each birth occurring after the mother has been covered by this **policy** for 10 consecutive months or more.	£100.	
18. Travel Cover.	Optional.	
For more information on the above please see:	Page 40	
19. Accidental Death Cover.	Not applicable.	£10,000.
For more information on the above please see:	Page 42	
20. 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 44	

Please see page 18 for details of the Optional Psychiatric Upgrade available with Executive.

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, **day-patient** and **out-patient** NHS radiotherapy and chemotherapy cash benefit or childbirth benefit.

Benefits table for VIP

The table on the following 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 this table in conjunction with the rest of your handbook.

Please make sure **you** call **us** on 0800 364 524 prior to **treatment** so **we** can confirm the extent of your cover and any limitations that may apply.

Benefits	Cover level two (amount payable)	Cover level one (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 at a **private hospital** or **day-patient unit** listed in the **Directory of Hospitals**.	
For more information on the above please see:	Pages 36 - 37	
2. Out of directory cash benefit. This benefit is payable if **you** receive private **in-patient** or **day-patient treatment** at 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 36 - 37	
3. **Specialists'** fees (Surgeons', anaesthetists' and physicians').	No annual maximum.	
For more information on the above please see:	Pages 38 - 39	
4. **In-patient** consultations. Benefit for a consultation with a second **specialist** arranged by the treating **specialist**.	No annual maximum.	
For more information on the above please see:	Pages 38 - 39	

Please see page 53 for an explanation of words that appear in **bold**

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.	
Out-patient treatment		
6. **Surgical procedures**.	No annual maximum.	
For more information on the above please see:	Page 27	
7. **Specialist** consultations.	No annual maximum.	
For more information on the above please see:	Pages 38 - 39	
8. **Diagnostic tests** on **specialist** referral.	No annual maximum.	
For more information on the above please see:	Page 25	
9. **Clinical practitioner** charges (including physiotherapy). 10. **Complementary practitioner** charges.	No annual maximum. However **we** will only pay for up to an overall maximum of ten sessions of **treatment** a **year** for GP referred physiotherapy and/or **complementary practitioner treatment**.	No annual maximum. However **we** will only pay for up to an overall maximum of 20 sessions of **treatment** a **year** for GP referred physiotherapy and/or **complementary practitioner treatment**.
For more information on the above please see:	Page 41	
11. 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 29 - 35 and CL1 page 32	
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 36 - 37	

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.
14. 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 otherwise would require **you** to be admitted for **in-patient** or **day-patient treatment**.	Paid in full when **treatment**: • 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.
15. NHS cash benefit. This benefit is paid for each night **you** receive free **treatment** under the NHS and only if: (i) **you** are admitted for **in-patient treatment** before midnight (ii) the **treatment you** receive under the NHS would have been **eligible** for benefit privately under this **policy**. There is no requirement for private **treatment** to have preceded any period in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.	£100 a night up to £5,000 a **year**.
16. **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 32

17. Childbirth benefit. **We** will pay this cash benefit for each birth occurring after the mother has been covered by this **policy** for 10 consecutive months or more.	£150.	
18. Travel Cover.	Optional.	
For more information on the above please see:	Page 40	
19. Accidental Death Cover.	Not applicable.	£15,000.
For more information on the above please see:	Page 42	
20. 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 44	

Please see page 18 for details of the Optional Psychiatric and Dental and Optical Upgrades available with VIP.

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, **day-patient** and **out-patient** NHS radiotherapy and chemotherapy cash benefit or childbirth benefit.

Optional Upgrades

Psychiatric Upgrade – available with VIP or Executive only	
If **you** have this option it will be shown as '+ Psych' in the name of the plan which is included on your membership statement and **you** will be covered for the **eligible treatment** of psychiatric conditions subject to all other benefit limitations and exclusions on your **policy**.	
Routine Dental and Optical Upgrade – available with VIP only	
If **you** have this option it will be shown as 'D&O' in the name of the plan which is included on your membership statement.	
1. Optical cover. **We** will pay 75% of the costs incurred. The maximum amount **we** will pay in a **year** is as shown.	Up to £140 each **year** for prescribed glasses or prescribed contact lenses.
For more information on the above please see:	Page 43
2. Eye test.	Up to £25 each **year** for an eye test.
For more information on the above please see:	Page 43
3. Dental care. **We** will pay 75% of the costs incurred. The maximum amount **we** will pay in a **year** is as shown.	Up to £150 each **year**.
For more information on the above please see:	Page 43

4 Arranging treatment and making a claim

How to arrange treatment and make 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 364 524 to check that the **treatment** is **eligible**. Please help **us** by having the following details available: • **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: • 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	• 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 many 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.

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**.

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.

Please see page 53 for an explanation of words that appear in **bold**

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 16.2(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.

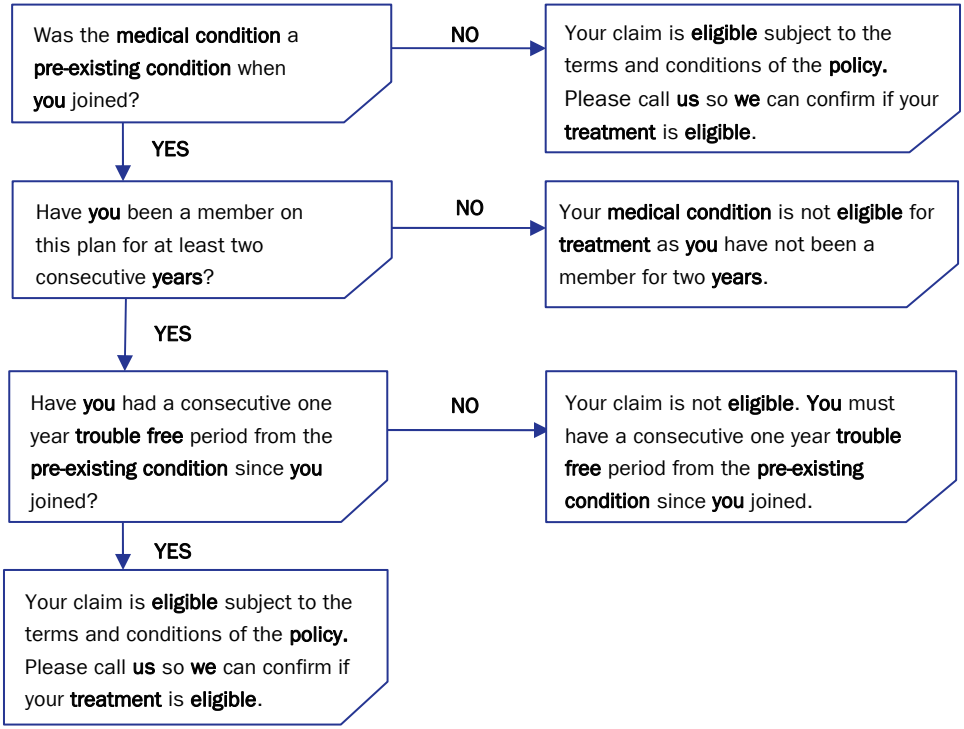
5 Existing medical conditions

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

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

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

If **you** did not provide your medical history when **you** joined, the following diagram shows how your **policy** works and the process **we** go through when assessing your claim. The **policy** terms are shown on the following page.



Please see page 53 for an explanation of words that appear in **bold**

Please note:

The following defined terms apply to this section:

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

pre-existing condition – any disease, illness or injury for which:

- **you** have received medication, advice or **treatment**; or
- **you** have experienced symptoms;

whether the condition has been diagnosed or not in the five years before the start of your cover.

trouble free – when you:

- have not had any medical opinion from a medical practitioner including GP's or **specialists**; or
- have not taken any medication (including over the counter drugs) or followed a special diet; or
- have not had any medical **treatment**; or
- have not visited a **clinical practitioner** or **complementary practitioner**;

for the **medical condition**.

We will provide cover for **treatment** of **medical conditions** that arise after **you** join. However, in the first two **years** of cover there is no cover for the **treatment** of pre-existing **medical conditions**.

Once **you** have been a member for two consecutive **years**, **you** may be able to claim for **treatment** of **pre-existing conditions** as long as **you** have had a **trouble free** period of one consecutive year for the **pre-existing condition** since **you** became a member.

There are some **medical conditions** – those that continue or keep recurring – that **you** will never be able to claim for. This is because **you** will never be able to have a consecutive one year **trouble free** period.

What happens when I want to make a claim?

If **you** completed a medical history declaration when **you** joined, your membership statement will show any specific exclusions that apply to your **policy**. **You** should call **us** to confirm that the **treatment you** need is **eligible**.

If **you** did not provide your medical history when **you** joined, **we** will need to assess your medical history before **we** can authorise your **treatment**. **We** may do this by asking for a medical information form or claim form from your GP or **specialist**, or by asking for your GP notes.

Be aware:

Because **we** need to assess your medical history, it is possible that **we** will not be able to authorise your **treatment** straight away. There may be a short delay before **we** can confirm if your **treatment** is **eligible**.

5.1 **We** pay for **eligible**:

(a) **Treatment** of a new **medical condition** that arises after **you** join.

(b) **Treatment** of **pre-existing conditions** once **you** have been a member for at least two consecutive **years** and have had a consecutive one year **trouble free** period.

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

(a) **Treatment** of **pre-existing conditions** for the first two **years** after **you** join.

(b) If **you** completed a medical history declaration when **you** joined: **Treatment** of any **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 recur(s) or which **you** should reasonably have known about (even if **you** had not consulted a doctor).

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

Please see page 53 for an explanation of words that appear in **bold**

6 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).

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.

(d) **Treatment** of astigmatism where the astigmatism arises from the surgical replacement of the lens of the eye.

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 except for the dental cash benefit available as an upgrade on the VIP **policy**.

(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.

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

(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.

(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 your Travel Cover handbook.

CL1 If **you** have cover level one there is extended cover for **treatment** received overseas, please refer to section 12 for details.

(s) Business Express members and VIP or Executive members who do not have the Psychiatric Upgrade: Any **treatment** of psychiatric illness.

Please see page 53 for an explanation of words that appear in **bold**

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 12 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.axappphealthcare.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** will 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.

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

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.

Please see page 53 for an explanation of words that appear in **bold**

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**. This **policy** is not intended to cover **you** against the costs of recurrent, continuing or long-term **treatment** of **chronic conditions**.

CL1 However, if **you** have VIP cover level one this **policy** also provides cover for the routine **out-patient** management of certain **specified chronic conditions**. Please refer to section 12 for details.

We define a **chronic condition** in the glossary on page 53 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. CL1 However, on VIP cover level one the **out-patient** management of certain **specified chronic conditions** is covered as detailed in Section 12. There are certain conditions that are likely to require ongoing **treatment** – such as Crohn's disease (inflammatory bowel disease) – which require management of recurrent episodes where the condition's symptoms deteriorate. Because of the ongoing nature of these conditions **we** will write to tell **you** when the benefit for that condition will stop.

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

We publish a leaflet which explains how **we** deal with payment for **treatment** of **chronic conditions**. This is available on **our** website: www.axappphealthcare.co.uk and can also be obtained from **us**. **You** will also find further explanation of how **we** deal with payment for **cancer treatments** on page 32.

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

- 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.

Please see page 53 for an explanation of words that appear in **bold**

What cover do I have for psychiatric treatment?

If **you** have the psychiatric upgrade available with VIP or Executive **you** have cover for the **treatment** of psychiatric illness, subject to all other benefit limitations and exclusions on your **policy**. If **you** have this option it will be shown as '+ Psych' in the name of the plan which is included on your membership statement.

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

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

Please note:

There is no cover for the **treatment** of psychiatric illness on Business Express or if **you** do not have the psychiatric upgrade available with VIP or Executive.

7.3 **We** pay for **eligible**:

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

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) Business Express members and VIP or Executive members who do not have the psychiatric upgrade: **Treatment** of any psychiatric illness.

8 Your cover for cancer treatment

Please note:

CL1 If **you** have cover level one refer to section 12 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 the section 'Existing medical conditions' 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.

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** specialist nurses in **our** Healthcare Solutions team. 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**, when **you** receive **eligible day-patient** or **out-patient** radiotherapy or chemotherapy **treatment** or **eligible in-patient treatment**. **Our** specialist nurses 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**.

Please see page 53 for an explanation of words that appear in **bold**

Summary of **cancer** cover for VIP, Executive and Business Express		
	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**.
	✘	**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 27 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 for further information. CL1 If **you** have cover level one, please refer to Section 12 for details of your extended cover for experimental surgical procedures.
Am I covered for preventive treatment?	✘	Preventive **treatment**, for example: • 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). These drug **treatments** will be covered for up to: • one year of such **treatment**; or • the period of the drug licence whichever is the shorter. The time limit starts from when **you** first started receiving that drug, however it may have been funded. 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**. 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. CL1 If **you** have cover level one, please refer to page 41 for details of your extended cover for drug **treatments** for **cancer** that are needed for a prolonged period of time.

Please see page 53 for an explanation of words that appear in **bold**

	✘	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.
	✘	**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?	✘	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 in section 6.3(b).
	✘	Any related administration costs (such as, but not limited to, transport costs and the cost of a donor search).

9 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.axappphealthcare.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.axappphealthcare.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 a CT, MRI or PET scan **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**.

Please see page 53 for an explanation of words that appear in **bold**

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).

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**.

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**.

Please note:

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

9.1 **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.

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

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

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

(c) Any charges made by, or incurred in an NHS hospital for ITU **treatment**, except as allowed for by 9.1(a).

10 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 procedure**s.

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 12 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**.

Please see page 53 for an explanation of words that appear in **bold**

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.axappphealthcare.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 **benefits table**. Please refer to Section 12 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.

10.1 **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.

10.2 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.

11 Treatment abroad

What overseas cover do I have on my policy?

This **policy** does not provide any cover for **treatment** received outside the **United Kingdom**.

However, your **company** may have purchased Travel Cover from **us**. If this is the case this will be reflected on your membership statement and **you** should read your Travel Cover handbook for details of your overseas cover.

CL1 If **you** have cover level one **you** also have extended cover for pre-planned **treatment** which takes place outside the **United Kingdom**, full details of which can be found on page 41.

12 Cover level one – Extended benefits

CL1 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 your 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**.

If **you** have cover level one, **you** have cover for an additional 10 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, **we** will pay the **eligible** charges in full up to the monetary limit shown in the core **benefits table**. However, 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 specified chronic conditions (VIP only)

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

We define what **we** mean by a **specified chronic condition** in the glossary on page 53 as: angina, asthma, diabetes, epilepsy, heart valve problems, high blood pressure, glaucoma, osteoarthritis, rheumatoid arthritis, thyroid problems and ulcerative collitis.

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 **you** also have extended cover for chemotherapy drugs and biological therapies such as trastuzumab (Herceptin) and bevacizumab (Avastin) 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 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 and fees 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 and fees 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 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** and **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: 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**.

Cover for accidental death

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

Please see page 53 for an explanation of words that appear in **bold**

13 VIP Routine Dental and Optical Upgrade

The following section only applies if **you** have VIP cover and have the Routine Dental and Optical Upgrade. If **you** have this option it will be shown as 'D&O' in the name of the plan which is included on your membership statement.

Optical benefit

We will reimburse up to £25 towards the cost of an eye test. **You** are entitled to this benefit each **year**. The eye test can be carried out by an ophthalmic optician or at any optician's shop or retail chain which provides that service. Just send **us** the receipt showing your name and confirming an eye test has been carried out and **we** will send **you** your benefit.

In addition **we** will reimburse up to £140 for prescribed glasses or prescribed contact lenses. **You** should pay for them and send **us** the receipt showing your name and showing clearly what has been provided. **We** will then send **you** your benefit.

Dental treatment

We will pay for **treatment** (including check-up or new dentures) up to the maximum benefit levels shown in the **benefits table**, if **you** have paid directly to a dentist or dental hygienist, who is registered with the General Dental Council. **We** will not pay benefit for any premiums **you** paid under a dental-care contract scheme.

14 Health at Hand

24 hour medical support for you and your family

Through our telephone health information service, Health at Hand, you have access to a qualified and experienced team of healthcare professionals, 24 hours a day, 365 days a year.

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.

The team of nurses, pharmacists, counsellors and midwives is on hand to give you the benefit of their expertise. They can 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.

Health at Hand – 0800 003 004

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

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

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

Please remember to have your membership number to hand before you call.

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.

Please see page 53 for an explanation of words that appear in **bold**

15 Additional information

When can I add other members?

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

Please ask your Human Resource Department for details.

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

If **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, **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 to live abroad. **We** have a range of international policies that have more appropriate benefits for anyone living abroad.

Can I cancel my policy?

No, this group scheme has been purchased by your employer, so **you** do not have the right to cancel it.

Will I have to pay income tax on the premiums?

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

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

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

- An excess is the amount of money **you** must contribute towards the cost of **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 page 53 for an explanation of words that appear in **bold**

Here are two examples of how the excess operates:

Example 1 – Executive with £100 excess	This **policy** has a benefit limit of £1,000 (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 £300 of **eligible diagnostic tests** – your first claim for that **policy year**.
Two	The £100 excess charge is applied.
Three	**We** pay £200 towards the £300 cost of **out-patient treatment** while **you** pay the £100 excess.
Four	This £300 total claim reduces your £1,000 benefit limit for **out-patient** consultations, **diagnostic tests**, **complementary practitioners**' and **clinical practitioners**' charges to £700.
Then...	Later in the same **policy year**, **you** suffer a different **medical condition** incurring costs of £750 for **eligible out-patient** consultations and **diagnostic tests** – £50 more than the **policy's** remaining £700 benefit limit.
So...	**We** pay £700 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 – Executive with £100 excess	This **policy** has a benefit limit of £1,000 (for each person each **year**) for **out-patient** consultations, **diagnostic tests**, **complementary practitioners**' and **clinical practitioners**' charges.
One	**You** require £1,050 of **eligible diagnostic tests** but the plan limit is £1,000.
Two	So **we** pay £1,000 for **treatment** – less the £100 excess – giving a total of £900.
Three	**You** pay the remaining £50 not covered by the **policy** plus the £100 excess, making a total of £150.
So...	Leaving no further benefit for **out-patient** consultations, **diagnostic tests**, **complementary practitioners**' and **clinical practitioners**' charges for the rest of the **policy year**.

16 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, Kent, 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, Kent, TN1 1BJ

Please see page 53 for an explanation of words that appear in **bold**

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

What we do with your personal data

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.

Please see page 53 for an explanation of words that appear in **bold**

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

16.1 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.

16.2 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 16.2(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) This **policy** is written in English and all other information and communications to **you** relating to this **policy** will also be in English.

16.3 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.

Please see page 53 for an explanation of words that appear in **bold**

17 Glossary

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

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

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

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

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

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

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.axappphealthcare.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**.

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. Unmarried children cannot stay on your **policy** after the renewal date following their 25th birthday.

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'.

CL1 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**.

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 psycho-sexual 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.

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

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.

Notes

At AXA PPP healthcare we are dedicated to supporting you.

Individual medical insurance

Company medical insurance

International medical insurance

Occupational health services

Employee assistance and wellbeing programmes

Sickness absence management services

Dental cover

Travel insurance

www.axappphealthcare.co.uk

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

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