Policy Booklet

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BAWA Policy Booklet August 2014

PHC
THE PERMANENT HEALTH COMPANY LIMITED

Your Policy Booklet

This Policy Booklet sets out the terms of your cover for the BAWA plan.
Throughout your Policy Booklet 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 25.

Additionally, when we refer to 'you' or 'your' throughout this document, we mean the **policyholder** and any **family members** named on the **policyholder's** Certificate of Cover. When you see 'we', 'us' or 'our' we are referring to the Permanent Health Company (PHC) on behalf of the underwriters, AXA PPP healthcare.

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HEALTHCARE AND LEISURE

1. Your cover

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

The policies are underwritten by AXA PPP healthcare Limited and administered by The Permanent Health Company Ltd (PHC). The policies are valid for 12 months and are renewable annually. In return for payment of the premium we agree to provide cover as set out in the terms of this **policy**. Please refer to the definition of **'policy'** in the glossary for details of the documents that make up your **policy**.

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

Summary of the BAWA Medicare Plan

BAWA Medicare provides cover for **eligible in-patient** and **out-patient treatment**. This includes benefits for **in-patient** accommodation, diagnostic procedures and surgeon's and anaesthetist's fees. It also includes **out-patient** services up to £1,400 per **policy year**.

*The above is only an overview of the benefits, please see your **Benefits Table** for full details.*

Be aware:

Your **policy** will not cover you for:	For further details:
Treatment for psychiatric conditions	Page 18
Treatment for **cancer** and related conditions	Page 18
Charges when **treatment** is not received in a designated hospital	Page 12
General dental procedures	Page 18
Routine pregnancy and childbirth	Page 20

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

Please note:

You can be reassured that the vast majority of **specialists** we recognise are **fee approved specialists** and we routinely pay their **eligible treatment** charges in full. We also pay **eligible treatment** fees in full with a **therapist** or **physiotherapist** and charges for an **acupuncturist, homeopath** or **practitioner** up to the level shown within the schedule of procedures and fees.

However if you choose to receive **treatment** under the direction of a **fee limited specialist** you may have to make a sizeable contribution to your **treatment** costs.

Please see the 'Who we pay for treatment' section of this Policy Booklet for full details.

2. Benefits Table

Please note:

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

Key to **Benefits Table**:

✓ = benefit is covered ✖ = benefit is not covered ppy = per person, per policy year

Benefits		**Notes**
In Patient & Day Care		
Nursing & accommodation Operating theatre/recovery room Prescribed medicines & drugs Diagnostic procedures Consultations **Specialist** physicians' fees Physiotherapy	✓	Fees for these benefits are paid in full within a designated **private hospital** or **day-patient unit.**
Surgeons' & anaesthetists' fees	✓	We will pay **eligible** fees in full under this benefit when a **specialist or anaesthetist** charges up to the level within our published schedule of procedures and fees. Please see the 'Who we pay for treatment' section of this Policy Booklet for full details.
Out-patient		All **out-patient** benefits below have a combined overall limit of up to £1,400 ppy
CT, MRI & PET scans on **specialist** referral	✓	Within the combined overall limit of up to £1,400 ppy for **out-patient** benefits.
Out-patient surgical procedures	✓	Within the combined overall limit of up to £1,400 ppy for **out-patient** benefits.
Consultations, including with **practitioners**	✓	Within the combined overall limit of up to £1,400 ppy for **out-patient** benefits.
Diagnostic procedures	✓	Within the combined overall limit of up to £1,400 ppy for **out-patient** benefits.
Physiotherapy	✓	Within the combined overall limit of up to £1,400 ppy for **out-patient** benefits we will pay for GP referred **physiotherapist treatment** up to an overall maximum of 10 sessions a **year.**
Therapist, acupuncturist and **homeopath treatment**	✓	Within the combined overall limit of up to **£1,400** ppy for **out-patient** benefits we will pay for GP referred **therapist, acupuncturist** and/or **homeopath treatment** in any combination up to an overall maximum of 10 sessions a **year.**

Additional benefits		
Hospital at home	✓	The Hospital at home benefit is for **treatment** provided at home or another clinically appropriate setting for the administration of intravenous antibiotics which otherwise would require you to be admitted for **in-patient** or **day-patient treatment.** We will pay 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.

3. Understanding your Certificate of Cover

Please take a moment to look at your Certificate of Cover and check that all your (and your dependants') details are correct. Please call our client support team on 01923 770000 if any amendments need to be made.

Your Certificate of Cover provides you with the following important information:

Do I have any exclusions on my plan?

This depends on the underwriting terms applicable to your Plan, please read the section "Existing Medical Conditions" in this Policy Booklet for further details.

One of the following codes will be shown below your Certificate number.:

MORI = moratorium
FMU = full medical underwriting
CPME = continued personal medical exclusions
MHD = medical history disregarded
VAR = various. This means that you and your dependants have different underwriting terms applied to them. These will be shown on page 2 of your Certificate of Cover enclosed with your membership documents.

All plans are subject to the general exclusions detailed in this Policy Booklet.

When does my plan year start?

The start date of your Plan is shown on your Certificate and each subsequent renewal notice.

Where a particular benefit has an annual limit payable, this amount is available in full each plan **year** for valid claims.

4. Your how to claim guide

claims line: 0117 9872315

Are you unwell?

The first thing you should do is see your General Practitioner (GP).

Simply call us as soon as your GP refers you for private **treatment**. We will send you a claim form for completion by you and your GP. Once the claim form has been returned to us, we can then make the necessary checks that the **treatment** is **eligible** before you incur any costs.

Sometimes we will need to contact your GP or **specialist** for more information before we can authorise a claim.

Be aware:

Your GP may make a charge for providing information to us and this charge is not covered by the **policy**.

Do you need to see a specialist, physiotherapist, practitioner, therapist, acupuncturist or homeopath?

Before seeing the **specialist**, **physiotherapist**, **practitioner**, **therapist**, **acupuncturist** or **homeopath** you must call the claims line on 0117 9872315 or Airbus Internal 62361 or RR Internal 96831.

All **treatment** must be pre-authorised through the helpline as we do not want you to incur any charges that may not be covered. We will pay **eligible** fees in full from a **fee approved specialist**, **physiotherapist** or **therapist**. We will pay **eligible** fees in full when an **acupuncturist**, **homeopath** or **practitioner** charges up to the level shown within the schedule of procedures and fees when you are under the direction of a **specialist** and additionally for **acupuncturist** or **homeopath treatment** under the referral of your GP. Please see the 'Who we pay for treatment' section of this Policy Booklet for full details.

Your Plan covers you for **treatment** at designated hospitals only. For current details of which hospitals you can use please contact Airbus Internal 62361 or RR Internal 96831 before commencing any **treatment**. If you have **treatment** at a non-designated hospital your **treatment** costs may not be covered.

What will we check when you phone?

Although the exact requirements will depend on your individual circumstances, our Claims Team are likely to discuss the following with you:

- If you would like us to support you in identifying a suitable **specialist**, you can ask your GP for an 'open referral'. This means your GP makes a general referral by stating what **treatment** is necessary and the type of **specialist** you require that **treatment** from, but they do not specify the **specialist's** name. If your GP has referred you to a specific person for **treatment** we will check they are recognised by us for benefit.
- If you need hospital **treatment** we will discuss with you the cover available and which hospitals, **day-patient units** and **scanning centres** are covered by your **policy**. Also if you are having a **surgical procedure** it would be helpful for us to know the procedure code so we can identify the exact **treatment** you will be having.

Completed claims forms

Please send your completed claim form and any invoices to BAWA.

Settling accounts

We normally receive accounts for **treatment** directly from **specialists** or hospitals. We can settle **eligible** bills direct with the hospital or **specialist**. If you have paid the accounts, then we will reimburse you. Should any accounts be sent direct to you please forward them immediately to BAWA. Some hospitals

may require you to pay for some services e.g. x-rays, blood tests etc., yourself. If this does happen please forward the receipted original invoices as above.

If you need further **treatment** that has not already been authorised, please call us to confirm your cover.

If at any time you require assistance please call the claims line on: 0117 9872315.

What happens if you 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.

What must you 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 you need to provide any other information?

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

Be aware:

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

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

What should you do if you 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 you do if the benefits you are 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 contact us if you are able to recover any part of your claims costs from any other party, for example if you have another insurance policy, cover through a state healthcare system or are legally entitled to recover costs from a third party; 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 progress and outcome of any action or settlement discussions (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 13.2 (e) 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. Who we pay for treatment

Your **policy** can provide benefit for **eligible treatment** provided by **specialists**, **physiotherapists, therapists**, **practitioners**, **acupuncturists** and **homeopaths.**

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.

What services under the direction of a fee approved specialist are eligible for benefit?

We pay **eligible treatment** charges made by a **fee approved specialist** for **consultations, diagnostic tests, treatment** in hospital and **surgical procedures** when you are referred for **specialist treatment** in that medical speciality by your GP or dentist.

You can be reassured that the vast majority of **specialists** we recognise are **fee approved specialists** so please contact us before receiving any **treatment** and we will help identify a **fee approved specialist** to treat you.

What services under the direction of a fee limited specialist are eligible for benefit?

If you have **eligible treatment** with a **fee limited specialist** we will only pay up to the amount shown within the schedule of procedures and fees towards their personal charges. This is available by contacting the claims line on 0117 9872315. If you receive **treatment** with a **fee limited specialist** you are likely to need to make a contribution to the fees charged by that **specialist**.

Be aware:

There are some medical providers who we do not recognise at all. If you received **treatment** from one of these medical providers we will not pay those fees or any other fees for **treatment** costs under the direction of that provider.

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 a **fee approved specialist**. 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. If you choose to receive **treatment** with an anaesthetist who is a **fee limited specialist**, we will pay up to the amount shown within the schedule of procedures and fees towards the charges for their services.

What services provided by a recognised therapist or physiotherapist are eligible for benefit?

Cover is available for **eligible treatment** with a **therapist** or **physiotherapist** when you are referred by your GP or a **specialist**.

We recognise a large number of **therapists** (chiropractors and osteopaths) and **physiotherapists** in the **UK**. We have identified which **therapists** and **physiotherapists** we pay **eligible treatment** fees in full for when you are under the direction of a **specialist**. Please contact us before receiving any **treatment** and we will help identify a **therapist** or **physiotherapist** we recognise.

If you choose to receive **treatment** from a **therapist** or **physiotherapist** who we do not recognise then there will be no cover for the cost of their charges.

We will pay up to an overall maximum of up to 10 sessions of **treatment** a **year** with a **therapist** and up to an overall maximum of 10 sessions of **treatment** a **year** with a **physiotherapist** as detailed in the **benefits table**.

If you require more than 10 sessions of **treatment** a **year** such **treatment** must be under the direction 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**.

What services provided by a recognised practitioner, acupuncturist or homeopath are eligible for benefit?

We will pay **eligible treatment** fees in full when an **acupuncturist, homeopath** or **practitioner** charges up to the level shown within the schedule of procedures and fees when you are under the direction of a **specialist** and additionally for **acupuncturist** or **homeopath treatment** under the referral of your GP**.** The schedule of procedures and fees is available by contacting the claims line on 0800 0687111.

We will pay up to an overall maximum of up to 10 sessions of **treatment** a **year** with an **acupuncturist** or **homeopath,** as detailed in the **benefits table**.

If you require more than 10 sessions of **treatment** a **year** such **treatment** must be under the direction 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**.

5.1 We pay for eligible:

(a) **Treatment** charges in full made by a **fee approved specialist, physiotherapist** or **therapist**.
(b) **Treatment** charges made by a **practitioner, acupuncturist** or **homeopath** up to the level set out in the schedule of procedures and fees or at the amount charged if lower.

5.2 What we do not pay for:

(a) Charges made by a **specialist, therapist, physiotherapist, acupuncturist** or **homeopath** when you have been referred by a member of your family, or if that **specialist, therapist, physiotherapist, acupuncturist** or **homeopath** is a member of your family.
(b) **Treatment** charges made by a **fee approved specialist, physiotherapist** or **therapist** 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.**
(c) Any charges made for written reports or any other administrative costs.

6.Where you are covered for treatment

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

Your Plan covers you for **treatment** at designated hospitals only. For current details of which hospitals you can use please contact Airbus Internal 62361 or RR Internal 96831 before commencing any **treatment**. If you have **treatment** at a non-designated hospital your **treatment** costs may not be covered.

6.1 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.

6.2 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 under 6.1 (a) above.

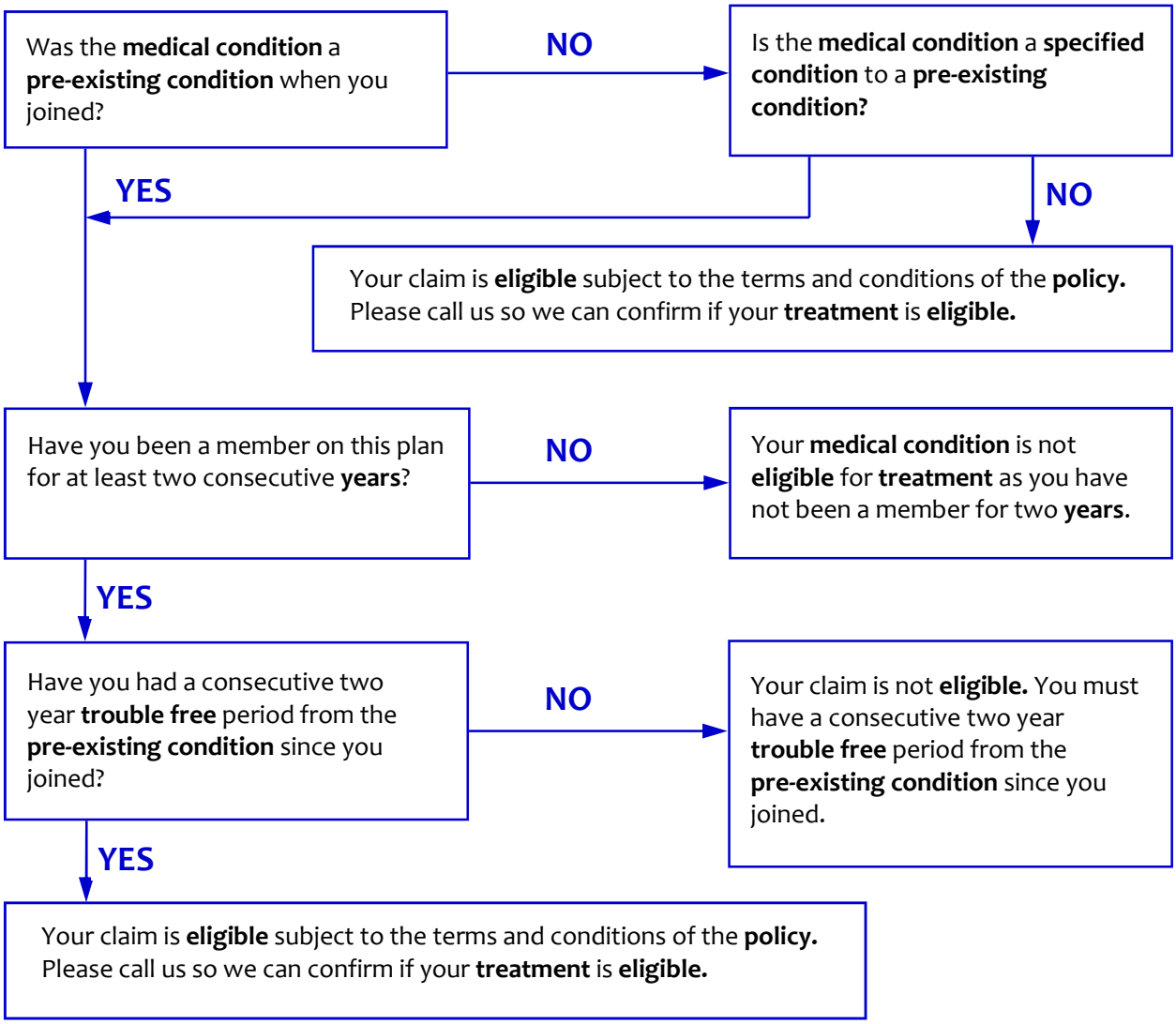
7. Existing medical conditions

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

This depends on the underwriting terms applicable to your own **policy**. Your Certificate of Cover will state which of the following underwriting terms (moratorium, full medical underwriting, continued personal medical exclusions or medical history disregarded) has been applied to your own **policy**:

Moratorium

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 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.
specified condition – the **medical conditions** listed in the table on the following page that are associated with the following pre-existing conditions: diabetes, raised blood pressure (hypertension) or undergoing monitoring as a result of Prostate Specific Antigen (PSA) test.

trouble free – when you:

- have not had any medical opinion from a medical practitioner including GPs 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 any medical professional including, but not limited to, **practitioners**, **physiotherapists**, osteopaths, dentists or opticians; 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** or for **treatment** of **specified conditions** where that pre-existing condition is one of those shown in the table below:

If you have the following **pre-existing condition:**	We will not pay for the **treatment** of the following **specified conditions** whatever their cause:
have been diagnosed with diabetes	• Diabetes • Ischaemic heart disease • Cataract • Diabetic retinopathy • Diabetic renal disease • Arterial disease • Stroke
are currently undergoing treatment for raised blood pressure (hypertension)	• Raised blood pressure (hypertension) • Ischaemic heart disease • Stroke • Hypertensive renal failure
are under investigation, having **treatment** or undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test	• Any disorder of the prostate

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

What happens when I want to make a claim?

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**.

7.1 We pay for eligible:

(a) **Treatment** of a new **medical condition** that arises after you join.
(b) **Treatment** of **pre-existing conditions** and where applicable, their **specified conditions,** once you have been a member for at least two consecutive **years** and have had a consecutive two year **trouble free** period.

7.2 What we do not pay for:

(a) **Treatment** of **pre-existing conditions** and **specified conditions** where that **pre-existing condition** is diabetes, raised blood pressure (hypertension) or you have been undergoing monitoring as a result of Prostate Specific Antigen (PSA) test for the first two **years** after you join.
(b) **Treatment** of any other **medical condition** detailed on your Certificate of Cover as excluded for benefit.

Full medical underwriting

If when you joined the scheme you completed a full medical history declaration then you will have made a declaration as to your medical history and we will have decided whether any exclusions for any **medical conditions** should be applied to your **policy**. Your Certificate of Cover will show the **medical conditions** for which we will not cover you for **treatment** and whether we can review that exclusion.

Continued Personal Medical Exclusions

If you transferred your **policy** to PHC on a continued personal medical exclusions (CPME) basis from an existing private medical insurance policy with another insurer we will have transferred the existing personal exclusions imposed by the previous insurer to your PHC Certificate of Cover. In the case of a previous insurer's moratorium, we will have transferred the balance of the un-expired moratorium period as applicable to the previous insurer.

Please note that when you transfer from one private medical insurer to another, with no break in cover, then you are transferring to a different policy with different benefits, terms and conditions. It is only the medical exclusions that were applied by your previous insurer that will be continued under your new **policy**, not the previous policy benefits, terms and conditions.

Medical History Disregarded (MHD)

If you joined the scheme on an MHD basis this means we will not have applied any exclusions for specific **medical conditions** to your **policy**.

The general exclusions of the BAWA Medicare Plan applies to all policies irrespective of the underwriting basis selected.

8. Recurrent, continuing and long-term treatment

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

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

We define a **chronic condition** in the glossary on page 25 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, continuing 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.

However, if you undergo one of the following **surgical procedures** on your heart we will continue to pay for your long-term monitoring, consultations, check-ups and examinations as long as you have a PHC private medical insurance policy with an appropriate benefit, subject to the terms and conditions of that policy at the time:

- Coronary artery bypass
- Cardiac valve surgery
- The implantation of a cardiac device, such a defibrillator or pacemaker
- Coronary angioplasty.

Please note:

We will not pay for routine checks that could typically be carried out by your GP, such as anticoagulation, lipid monitoring or blood pressure monitoring.

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.thephc.co.uk and can also be obtained from us.

8.1 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) Routine follow-up consultations for the ongoing monitoring after the following **surgical procedures** for heart conditions:
- Coronary artery bypass
- Cardiac valve surgery
- The implantation of a cardiac device, such as a defibrillator or pacemaker
- Coronary angioplasty

(c) **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.

(d) Hormone replacement therapy (HRT) only when it is medically indicated as a result of 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.

8.2 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, except as allowed in 8.1 (b) above.
(e) Regular or long-term kidney dialysis in the case of chronic kidney failure.

9. Your cover for certain types of treatment

What cover do I have for psychiatric treatment?

Your Plan does not include cover for psychiatric 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).

9.1 We pay for eligible:

(a) **Diagnostic tests** ordered by a **specialist**.
(b) Oral **surgical procedures** listed below following referral by a dentist:
- reinsertion of your own teeth following a trauma
- surgical removal of impacted teeth, buried teeth and complicated buried roots
- enucleation (removal) of cysts of the jaw.

(c) Initial reconstructive surgery to restore function or appearance after an accident or following surgery for a **medical condition**, provided that:
- we have covered you continuously under a policy of ours since before the accident or surgery happened
- we agree the cost of the **treatment** in writing before it is done (see also 9.2 (m)).

(d) **Treatment** of astigmatism where the astigmatism arises from the surgical replacement of the lens of the eye (see also 9.2 (o)).

9.2 What we do not pay for:

(a) **Treatment** of **cancer** or any related condition.
(b) **Diagnostic tests** ordered by anyone other than a **specialist**.
(c) Any dental procedures, including referrals to dental specialists such as periodontists, endodontists, prosthodontists or orthodontists.
(d) **Treatment** which is not medically necessary or which may be considered a matter of personal choice.
(e) **Treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide.
(f) **Treatment** of, or **treatment** which arises from or is in any way connected with, alcohol abuse, drug abuse or substance abuse.
(g) Any costs incurred as a consequence of **treatment** that is not **eligible** under your **policy**, including increased **treatment** costs.
(h) Any **treatment** of warts of the skin.
(i) Vaccinations, routine medical examinations, preventive screening/examinations, investigative tests, including monitoring of a condition irrespective of:
1) whether treatment for the condition has taken place under the plan,
2) your previous medical history,
3) your family medical history.

(j) Preventive **treatment**.
(k) **Out-patient** drugs or dressings.
(l) The costs of providing or fitting any external prosthesis or appliance.
(m) Cosmetic (aesthetic) surgery or **treatment**, or any **treatment** relating to previous cosmetic or reconstructive **treatment**. (See also 9.1 (c)).
(n) 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).
(o) Any other **treatment** of astigmatism or any other refractive errors. (See also 9.1 (d)).
(p) Any **treatment** to correct long or short-sightedness.
(q) **Treatment**, relating to learning disorders, educational problems, behavioural problems, physical development or psychological development, including assessment or grading of such problems. This includes, but is not limited to, problems such as dyslexia, dyspraxia, autistic spectrum disorder, attention deficit hyperactivity disorder (ADHD) and speech and language problems.
(r) 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**.
(s) Any **treatment** costs incurred as a result of engaging in or training for any sport for which you receive a salary or monetary reimbursement, including grants or sponsorship (unless you receive travel costs only).
(t) 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.
(u) Claims on this **policy** if you live outside the **United Kingdom**.
(v) Any **treatment** received outside the **United Kingdom**.
(w) Transplants:

1) any **treatment** related to either donor or recipient for any procedure involving transplantation or implantation operations or **treatment** directly or indirectly related to such operations (other than corneal, skin grafting, coronary artery bypass operations or osteochondral grafting).
2) any **treatment** related to donor or autologous transplants of bone marrow.
3) any treatment related to stem cell procedures.
4) 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).

(x) Weight reduction or **treatment** of obesity, or any care involving weight reduction as the main method of **treatment**, including medical, surgical or psychiatric care.
(y) Any **treatment** costs incurred as a result of your active involvement in criminal activity.
(z) Charges for general chiropody or foot care (including but not limited to gait analysis and the provision of orthotics), even if this is carried out by a surgical podiatrist.
(aa) Any charges for primary care services, such as any services that would typically be carried out by a GP or dentist.
(bb) Any separate charge made by a specialist for consultations within 10 days after they have performed the surgical procedure. Our payment of the fee for the surgical procedure will include an allowance for those consultations.

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.

9.3 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 contact the claims team.

9.4 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 Care Excellence for specific purposes to be considered proven safe and effective therapies.

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 contact the claims team so we can confirm the extent of the cover we will provide before you undertake any **treatment**.

9.5 We pay for eligible:

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**.

9.6 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, **treatment** designed to increase fertility (including **treatment** to prevent future miscarriage), investigations into miscarriage and assisted reproduction, or any consequence of any of the above or any **treatment** for them.

(c) Contraception or sterilisation (or its reversal) or any consequence of any of them or any **treatment** for them.

(d) **Treatment** of or related to sexual dysfunction, or any consequence of it.

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

(f) Any **treatment** for a baby born after taking any prescription or non-prescription drug or other **treatment** to increase fertility, or as the result of any method of assisted conception such as IVF, while the baby requires **treatment** in a Special Care Baby Unit or requires paediatric intensive care.

10. 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.

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 after taking any prescription or non-prescription drug or other **treatment** to increase fertility or as the result of any method of assisted conception, such as IVF. 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 cancel your **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.

Can I cancel my policy?

You have a 14 day cooling off period when you join and at each renewal. Please see section 11.1 (g) 'Your rights and responsibilities'.

11. Complaint and regulatory information

What should I do if I have reason to complain?

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

If you think things have gone wrong for you and you are unhappy with us, please contact:

The Managing Director
The Permanent Health Company Limited
32 Church Street,
Rickmansworth
Hertfordshire, WD3 1DJ
Tel: **01923 770000**

in the first instance and we will try to resolve your complaint.

We will acknowledge your complaint upon receipt. To allow us to investigate your complaint fully, the Financial Conduct Authority (FCA) gives us up to eight weeks to get back to you. However, we will respond sooner than this if we are able.

The Financial Ombudsman Service

The Financial Ombudsman Service will review your complaint if you remain dissatisfied after our final response has been issued, the address you need to write to is:

The Financial Ombudsman Service
South Quay Plaza,
183 Marsh Wall,
London E14 9SR
Telephone: **0800 023 4567**
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**; and
- 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 generally review a complaint where:

- you have not received a final decision;
- the final decision issued by a company was received more than six months ago; or
- your complaint already involves (or has involved) legal action.

What regulatory protection do I have?

The Financial Conduct Authority (FCA)

The Permanent Health Company Limited is authorised and regulated by the Financial Conduct Authority (FCA). AXA PPP Healthcare is authorised by the Prudential Regulation Authority (PRA) and regulated by the PRA and the FCA.

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

The FCA have set out rules which regulate the sale and administration of general insurance which we must follow when we deal with you. The PHC's FCA register number is 310293, AXA PPP healthcare's register number is 202947.

This information can be checked by visiting the FCA register which is on their website: www.fca.gov.uk/register or by contacting the FCA 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). The scheme is governed by FCA 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:

How is my personal data used?

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 send personal and sensitive personal information in confidence for processing by other companies and intermediaries including those located in countries outside the European Economic Area (EEA) including to countries where the laws protecting personal information may not be as strong as in the EEA. We take steps to ensure that any sub-contractors give at least the same protections as we do.

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 legal holder of the insurance **policy** we send correspondence about the **policy** to the **policyholder**. If any **family member** over 18 insured under the **policy** does not want us to do this they should apply for their own **policy**.

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

If you have agreed we, and other members of the PHC Group, may use the information you have provided to us to inform you by letter, telephone, email or mobile message of products and services such as special offers and healthcare information. If you change your mind please contact our team of Personal Advisers or write to us at the address on the back of this Policy Booklet otherwise we will assume that, for the time being, you are happy to be contacted in this way.

Legal rights and responsibilities

11. 1 Your rights and responsibilities

(a) Your **policy** is for one **year**. Prior to the end of any **policy year** we will write to the **policyholder** to advise on what terms the **policy** will continue, provided the **policy** you are on is still available. If we do not hear from the **policyholder** in response we will renew your **policy** on the new terms. Where you have opted to pay premiums by Direct Debit or other payment method, we may continue to collect premiums by such method for the new **policy year**. Please note that if we do not receive your premium, you will not be covered. If the **policy** you were on is no longer available we will do our best to offer you cover on an alternative policy.

(b) You must make sure that whenever you are required to give us any information, all the information you give us is sufficiently true, accurate and complete so as to give we a fair presentation of the risk we are taking on. If we discover later it is not, then we can cancel the

policy or apply different terms of cover in line with the terms we would have applied had the information been presented to us fairly in the first place.

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

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

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

(f) You must pay your premium when it is due.

(g) The **policyholder** may cancel this **policy** by contacting us during the 14 day cooling off period. The 14 day cooling off period commences on the day that the contract is concluded or the day that full **policy** terms and conditions are received, whichever is the later. The 14 day cooling off period also applies from each renewal date. If the **policy** is cancelled during the 14 day cooling off period we will return any premium paid for the **policy** providing no claims have been made on the **policy** in relation to the period of cover before cancellation (being no more than 14 days' cover).
If you incur **eligible** claims costs within that period of cover we reserve the right to require the **policyholder** to pay for the services we have actually provided in connection with the **policy** to the extent permitted by law and any return of premium is subject to this. If the **policyholder** does not cancel the **policy** during the cancellation period the **policy** will continue on the terms described in this handbook for the remainder of the **policy year**.

11. 2 PHC and 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) We, or any person or company that we nominate, have subrogated rights of recovery of the **policyholder** or any **family members** in the event of a claim. This means that we will assume the rights of policyholders or any family members to recover any amount which they are entitled, for example from someone who caused your injury or illness, another insurer or a state healthcare system, and which we have already covered under this **policy**.
The policyholder must provide us with all documents, including medical records, and provide any reasonable assistance we may need to enable us to exercise these subrogated rights and must not do anything to prejudice such rights at any time. We reserve the right to deduct from any claims payment otherwise due to you or any amount equivalent the amount you could recover from a third party of state healthcare system.

(e) If you break any of the terms of the **policy** which we reasonably consider to be fundamental, we may (subject to 11.2(f)) 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.

(f) 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.

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

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

12. 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.

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

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

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

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

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

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

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

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.

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.

fee approved specialist – a **specialist** who we have identified as someone whose fees for **eligible treatment** we routinely pay in full.

fee limited specialist – a **specialist** who we have identified as someone to whom we will only pay up to the amount shown within the schedule of procedures and fees towards their **eligible treatment** charges. The schedule of procedures and fees is available by contacting the claims line on 0800 0687111.

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

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

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

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

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

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

physiotherapist – a medical practitioner who practices physiotherapy and who 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 physiotherapist for benefit purposes. 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.

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 Certificate of Cover and our letter of acceptance
- any Statements of Fact we have sent you

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

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 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, psychologists, psychotherapists and speech therapists.

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

private hospital – a hospital designated for use by Airbus Internal or RR internal.

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

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

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

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

therapist – a medical practitioner with full registration under the Medical Acts, who is a practitioner in physiotherapy, osteopathy or chiropractic who is registered under the relevant Act; and who, in all cases, meets our criteria for therapist recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise them as a therapist 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.

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.

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