



Your plan terms and conditions

BUSINESS AND
CORPORATE HEALTHCARE



Welcome to PruHealth

About this document

This document reflects the plan terms and conditions of your Business and Corporate Healthcare plan as agreed between PruHealth and your employer. Please refer to this document and your certificate of insurance for full details of the cover and any exclusions that may apply.

You will also find reference to our Vitality programme in this document. Please note that the services, discounts and rewards offered under our Vitality programme may change during the course of a plan year, as described in the 'Vitality' section of this document and Appendix 4.

About PruHealth

PruHealth was launched in October 2004 and is a joint venture between Prudential and Discovery Holdings, the South African health insurance leader. PruHealth is now the fourth largest private medical insurer in the UK with a market share of around 10.5%.

About Prudential UK and Discovery Holdings

Established in 1848, today Prudential plc is an international financial services group with significant operations in Asia, the US and the UK. It serves approximately 25 million customers and has £349.5 billion of assets under management (as at 30 June 2011).

Discovery Holdings was founded in 1992 as a specialist health insurance company in South Africa. It is now the market leader in healthcare in South Africa with over 2.5 million customers there.

For more information visit www.prudential.co.uk and www.discovery.co.za

The purpose of this plan

This plan is designed to meet the needs of people who wish to ensure their health requirements are met quickly; it complements the services provided by the NHS but does not replace them. We aim to offer increased choice and access to high quality, private facilities. Our products will also reward you if you make an effort to lead a healthy lifestyle.

Contacting us

For more information or further clarification on the benefits, exclusions and the rules included in this document, you can contact us as follows:

Online:

Via our Member Zone at pruhealth.co.uk/member and send us a secure message.

By post to:

PruHealth Customer Services
Stirling FK9 4UE

How we will communicate with you

We will use your (the **insured member's**) email address as the primary form of contact regarding this scheme and our Vitality programme. Please note we generally do not send paper copies of our documentation or Vitality information to you unless explicitly requested. All plan documentation can be found by logging in to our secure website.

About this plan wording

We have tried to make sure that the wording in this document is as clear and straightforward as possible. Please take time to read it carefully alongside your certificate of insurance, hospital list and any changes we tell you about, as they all form part of the contract of insurance and should be read as if they are one document.

Your certificate of insurance

It is especially important that you always refer to your certificate of insurance before making a claim as this shows which cover options you have, what limits if any apply, any **excess** that's payable and how it is paid, and any special terms such as personal exclusions that are specific to you and your **insured dependants**.

If a cover option doesn't show on your certificate of insurance then you do not have that cover.

Certain words used within these terms and conditions have special meaning that we'd like to draw to your attention:
 We/us/our – means PruHealth
 You/your – means the **insured member** and **insured dependants**
 References to the **planholder** mean the **company** or employer which has the contract with us.

We have printed the remaining defined words in bold to help you identify them as you read through this document. You'll find a full explanation of each word in the 'Definitions' section on page 54. If you have any queries about your plan, please speak to your Group Secretary, or call our customer services team who will be happy to help you.



PruHealth is committed to a policy of full transparency and as such we highlight any important details we think you ought to pay close attention to with this icon, in order to ensure you understand your cover and don't get any surprises when you need to make a claim. Your plan terms and conditions need your close attention, which is why our Cover Check icon appears on the cover of this document.

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Summary of cover and exclusions

This summary is intended to give you a brief overview of our Business and Corporate Healthcare plans. For full details of your own cover, please refer to your certificate of insurance and the terms and conditions contained later in this document.

What are PruHealth's Business and Corporate Healthcare plans?

- Our Business and Corporate Healthcare plans aim to cover the costs of private medical treatment for acute medical conditions for **UK** residents. Our Core cover provides full cover for **in-patient** and **day-patient** hospital treatment and **out-patient** surgical procedures. It provides a good level of cover for **cancer** treatment, though it limits cover for biological therapies to 12 months. Other cover options your employer can choose from include:
 - **Out-patient** tests and **treatment**
 - Psychiatric cover
 - Therapies cover
 - Dental cover
 - Travel cover
- Our Business and Corporate Healthcare plans also include our Vitality programme that can help you lead a healthier lifestyle and rewards you for doing so.

Please read the 'Your healthcare cover explained' section together with your certificate of insurance to find out what cover you have.

How long does the plan last and how can it change?

- Business and Corporate Healthcare is an annual insurance contract which means that the premiums, benefits, terms and conditions can change at each **annual renewal date**.
- Your plan is bound by English law and comes under the jurisdiction of the **UK** courts.

What does this plan not cover?

- Like all health insurers there are some conditions and **treatments** we don't cover. Here are some of the key ones but please refer to the section later in this document for a full list:
 - Any regular monitoring or **treatment** of chronic (long-term) medical conditions. Examples of **chronic conditions** include diabetes, HIV/AIDS and allergies
 - **Treatment** received outside the **UK**
 - Emergency **treatment** or visits to your **GP**
 - Pregnancy and childbirth
 - Cosmetic **treatment**
 - Organ transplants
 - Experimental or unproven treatment or practices
 - **Treatment** related to developmental problems such as learning difficulties and speech disorders
 - **Treatment** for obesity
- Our plans are designed to cover new conditions that arise after your plan starts with us, so you may also have exclusions personal to you that will show on your certificate of insurance, if you completed a health questionnaire.
- If you joined under our moratorium clause, any medical conditions you've had in the five years leading up to your **cover start date** are automatically excluded. These conditions can become eligible for cover if you don't need **treatment** for them or any **related conditions** for two continuous years after your cover starts

Please read the section 'Exclusions (what's not covered)' for full details

What happens if I go to a hospital that's not on my list?

- It's important to choose the hospital list that suits your individual requirements. You should only go to a **hospital** on your chosen list for your **treatment** as you're only covered for **treatment** at those **hospitals**;
- If you decide to go to a **hospital** that's not on your list, then you'll have to pay 40% of the costs of your **treatment** (excluding your **specialist's** fees);

How does Vitality work?

- We believe your health insurance should do more than pay claims when you're ill; it should help you lead a healthier lifestyle too. Our Vitality programme is unique in how it rewards you for doing so.
- With Vitality, you can get discounted gym membership with selected gyms and extra Nectar points when you buy certain healthy foods at Sainsbury's. If you have access to Vitality Plus (as stated on your certificate of insurance), you can also earn big discounts with our reward partners depending on your Vitality status.
- Your employer may choose to upgrade your cover to include a Personal Health Fund that lets you buy services and **treatments** not usually available with health insurance.
- Because we are working with a range of partners and services that can change over time, we may change the way we award points and/or the eligible activities in the Vitality programme. We may change the partners and the incentives we offer from time to time. Prices with our Vitality partners may also increase during the **plan year**.

Please read the section called 'Vitality' to find out more. If your certificate of insurance shows you have the Personal Health Fund option, then please also read Appendix 4 called 'Vitality'.

What happens if I leave the company?

- Your cover ends on your leaving date which means we won't pay for any more **treatment** you have after that date even if you're in the middle of **treatment** at the time or we've authorised that **treatment** in advance. Depending on your age and how long you've been covered under your **company** scheme, you may be eligible to continue your cover with us on an individual plan with the same personal underwriting terms.
- Please also note that you may still be subject to the notice period of any relevant Vitality partner and to any other relevant terms and conditions of that Vitality partner. Also, there will be no refund in respect of any Vitality activities or Vitality points earned once your cover has ended.

What happens if I complain but am not happy with the outcome?

- We hope this never happens but if it does you can take your complaint to the Financial Ombudsman Service once you've received our final decision. This is a free service to you and does not affect your legal rights. You'll find contact details and information on how to make a complaint later in this document but here's their website address for your convenience: www.financial-ombudsman.org.uk.

What protection is there if PruHealth goes out of business?

- As a PruHealth **member**, you're protected by the Financial Services Compensation Scheme. If we're unable to pay your claim because we've become insolvent or are no longer in business, the scheme may arrange to transfer your plan to another insurer, or provide a new plan. If this isn't possible it will provide compensation of 90% of the claim, with no upper limit. More details can be found on their website: www.fscs.org.uk.

Your healthcare cover explained

In this section we have set out details of the cover options and the exclusions that apply to each option. Other exclusions applying to your plan are contained within the 'Exclusions (what's not covered)' section on page 23. You may also have exclusions personal to you based on your medical history. You will find details of any personal exclusions in your certificate of insurance.

Important notes

The purpose of this plan is to provide you with cover for eligible **treatment**, once you've been referred to an appropriate **specialist** by your **GP** or **dental practitioner**, that:

- aims to cure an **acute condition** or the **acute flare-up of a chronic condition** or to return you to your state of health immediately before suffering an **acute condition** or **acute flare-up of a chronic condition**
- is given by a **specialist** recognised in writing by us and takes place at a **hospital** or other facility on the most recent hospital list applicable to you
- is appropriate for your condition and established medical practice at the time of the **treatment**
- is covered by the benefits of this plan, subject to any terms and conditions

Subject to any limits that apply, we will pay for eligible **treatment** costs after taking off any **excess** that may apply under the plan.

What happens if you go to a hospital not on your list

Please refer to your certificate of insurance to find out the name of your selected hospital list; you should then go to our website to find out which **hospitals** are available to you from that list.

If you choose to have **treatment** in a **hospital** that is not on your list, then you will have to pay 40% towards the costs of your **treatment** (excluding your **specialist's** fees).

In the rare circumstances where eligible **treatment** is unavailable in a local **hospital** on your selected hospital list, we will help you find another **hospital** on your list where it can take place. Sometimes this may mean you having to travel further than would normally be the case.

What happens if your cover ends

This plan covers you for eligible **treatment** that takes place while the plan is still in force (in other words, whilst the plan is still active and has not been cancelled or lapsed for any reason) and you are still an **insured member** or **insured dependant** of this scheme. We do not pay for **treatment** that takes place after your cover has ended, even if this is a continuation of **treatment** that started while you were still covered by this plan, or even if we've authorised it in advance but the **treatment** is now going to take place after your cover has ended. In certain circumstances, we can offer you the opportunity to continue your cover on an individual plan without changing your **medical underwriting** terms. Please refer to paragraph 5.7 on page 53 for more details.

'Core cover' applies to each insured person

The following tables show all of the cover options that can be chosen. 'Core cover' applies to the **insured member** and any **insured dependants** and, unless you see the following symbol '†' which indicates that a limit applies, then your 'Core cover' gives you 'full cover' for eligible **treatment** in a **hospital** on your selected hospital list.

Your company can choose to limit or remove cover options even under 'Core cover'. Please always check your certificate of insurance to find out exactly what cover you have.

What we mean by 'full cover'

Wherever we say 'full cover' in your certificate of insurance we mean all of your eligible costs will be covered in full (unless any **excess** applies) providing you're being treated in a **hospital** or other facility that is on your hospital list and by a **specialist** recognised by us. For example, if you need an operation our 'full cover' promise includes paying your surgeon's and anaesthetist's fees in full. Your **company** may have chosen our 'Fee maxima' option which limits our cover for **specialists'** fees if they charge more than we would expect them to for a given **treatment**. Please check your certificate of insurance to see if this applies.

Other cover options

With the exception of 'Core cover', all other cover options such as 'Out-patient cover' and 'Therapies cover' are only available to you if your company has chosen them and they show on your certificate of insurance.

If a cover option does not show on your certificate of insurance then you are not covered for it.

The column on the right called 'What's not covered' shows some of the exclusions that apply to each aspect of cover. However, a full list of exclusions is included on page 23. Please also read the 'Important information about your cover' section which tells you more about some of the options. This section can be found on pages 29 - 33.

Wherever you see this symbol (†) limits apply and you should refer to your certificate of insurance for more details.

Core cover

Core cover - Hospital Fees

What's covered	What's not covered
<p>Charges for in-patient and day-patient treatment at a hospital on your chosen hospital list</p> <ul style="list-style-type: none"> ■ accommodation, nursing, drugs given for immediate use while in hospital, intensive care ■ operating theatre charges, surgical dressings and drugs ■ surgical appliances needed as a vital part of an operation ■ diagnostic tests, including pathology, radiology, CT, MRI and PET scans ■ physiotherapy (when part of in-patient treatment only). <p><i>Please also see 'Important information about your cover' paragraph 1.3</i></p>	<ul style="list-style-type: none"> ■ medical aids or appliances (e.g. neck collars, splints and foot supports) ■ mobility aids (e.g. wheelchairs and crutches) ■ spectacles, contact lenses, hearing aids or cochlear implants ■ the provision or fitting of any external prosthesis ■ drugs and dressings that you take home ■ personal expenses such as newspapers, telephone calls, additional meals.

Core cover – Specialist Fees

What's covered	What's not covered
<p>Specialist fees for in-patient and day-patient treatment that takes place at a hospital on your chosen hospital list</p> <ul style="list-style-type: none"> ■ surgeons' and anaesthetists' fees for operations and surgical procedures performed as an in-patient or day-patient ■ physicians' fees and other specialist consultations. 	<ul style="list-style-type: none"> ■ treatment given by a specialist not recognised by us

Core cover - Out-patient scans

What's covered	What's not covered
<p>CT, MRI and PET scans undertaken as an out-patient at a hospital on your chosen hospital list.</p> <p><i>Please also see 'Important information about your cover' paragraph 1.3</i></p>	<ul style="list-style-type: none"> ■ if the scan is arranged by your GP or therapist, such as physiotherapist

Core cover - Out-patient surgical procedures

What's covered	What's not covered
<p>Charges for out-patient surgical procedures* at a hospital on your chosen hospital list or in the consultant's specialist consulting rooms, where appropriate</p> <ul style="list-style-type: none"> ■ surgeons' and anaesthetists' fees ■ operating theatre charges, surgical dressings and drugs used during the surgical procedure ■ any other related and necessary medical treatment that takes place on the same day as the surgical procedure <p>*Out-patient surgical procedure means an operation or other invasive procedure carried out on an out-patient basis.</p> <p><i>Please also see 'Important information about your cover' paragraph 1.3</i></p>	<ul style="list-style-type: none"> ■ out-patient treatment that is not a surgical procedure ■ medical aids or appliances (e.g. neck collars, splints and foot supports) ■ mobility aids (e.g. wheelchairs and crutches) ■ spectacles, contact lenses, hearing aids or cochlear implants ■ the provision or fitting of any external prosthesis ■ drugs and dressings that you take home ■ personal expenses such as newspapers, telephone calls, additional meals.

Core cover - Cancer treatment

What's covered

Our Core cover includes cover for **cancer treatment**, including **in-patient**, **day-patient** and **out-patient treatment**. We even cover eligible **treatment** at home where this would otherwise require **in-patient** or **day-patient treatment**.

Here's a quick summary of the cover available but please refer to *Appendix 3* on page 75 and your certificate of insurance for more details about this important part of your cover:

- Surgery, including reconstructive surgery
- Radiotherapy
- Chemotherapy (the use of drugs to destroy **cancer** cells)
- Biological therapy (which the National Institute for Health and Clinical Excellence (NICE) defines as: 'A substance which aids the body's natural defence system in order to inhibit the growth of a tumour') † (limits apply unless you have our 'Full Cancer Cover' option)
- Stem cell therapy
- **Specialists'** fees for supervising the **treatment**
- **Out-patient treatment**, including **diagnostic tests** and monitoring or follow-up consultations that are considered medically necessary.
- Donation for each day spent in a hospice †.

Please also see 'Important information about your cover' paragraph 1.11

What's not covered

Please refer to *Appendix 3* for more details about our cover for **cancer treatment** and any relevant exclusions

Core cover – Private Ambulance	
What's covered	What's not covered
<p>The use of a private ambulance for transfer between hospitals, whether NHS or private, if a specialist recommends it as medically necessary.</p> <p><i>Please also see 'Important information about your cover' paragraph 1.9</i></p>	<ul style="list-style-type: none"> where use of the private ambulance is not medically necessary

Core cover - NHS Hospital Cash Benefit	
What's covered	What's not covered
<p>NHS Hospital Cash Benefit for</p> <ul style="list-style-type: none"> eligible in-patient treatment that you choose to have as a non-paying NHS patient even though you could have had the treatment in a private facility † eligible day-patient treatment that you choose to have as a non-paying NHS patient even though you could have had the treatment in a private facility † 	<ul style="list-style-type: none"> if treatment is not eligible under this plan if treatment is not available at a private facility on your hospital list for emergency admission to an NHS hospital if you choose to transfer to a private hospital for part of your treatment, then no benefit is payable for any of the nights you have spent as a non-paying NHS patient.

Core cover - Childbirth Cash Benefit	
What's covered	What's not covered
<p>A cash amount payable on the birth of a child. This benefit is payable once only per child †</p> <p><i>Please also see 'Important information about your cover' paragraph 1.8</i></p>	<ul style="list-style-type: none"> if you've not been covered under the plan for at least ten months before the birth

Core cover - Parent Accommodation

What's covered

Accommodation for you or your insured husband, wife or partner to stay with your insured child under age 14 while they are receiving **in-patient treatment** in a **hospital** on your list.

Please also see 'Important information about your cover' paragraph 1.10

What's not covered

- personal expenses

Core cover - Pregnancy Complications

What's covered

Charges for **in-patient** and **day-patient treatment** at a **hospital** on your chosen hospital list for the following conditions and directly associated complications:

- ectopic pregnancy
- miscarriage
- missed abortion
- still birth
- post partum haemorrhage
- retained placental membrane
- hydatidiform mole

but we will not cover **hospital** charges and **specialists'** fees where you've arranged in advance to have your baby in a private facility, except where any costs are directly related to eligible **treatment** of the above conditions and directly associated complications.

What's not covered

- antenatal care
- normal pregnancy and childbirth
- any complication of pregnancy or directly **related condition** that the mother is aware of at her **cover start date**
- any complication of pregnancy and childbirth except ectopic pregnancy, miscarriage, missed abortion, stillbirth, post partum haemorrhage, retained placental membrane or hydatidiform mole
- caesarean sections
- any complications following infertility **treatment**, IVF or other assisted reproduction
- investigations and **treatment** of recurrent miscarriages.

Core cover - Oral Surgery

What's covered	What's not covered
<p>Charges for in-patient and day-patient treatment at a hospital on your chosen hospital list for the following oral surgical procedures only:</p> <ul style="list-style-type: none"> ■ re-implantation of teeth following an accident ■ elective reduction of facial and mandibular fractures following an accident ■ surgical removal of impacted teeth, buried teeth and complicated buried roots (providing this is for an acute condition) ■ infections causing facial swelling requiring surgical drainage ■ removal of cysts of the jaw ■ apicectomy. 	<ul style="list-style-type: none"> ■ elective surgery to correct conditions of the jaw bones and/or facial skeleton ■ procedures to prepare for orthodontics or prosthetic surgery ■ any other dental treatment or oral surgical procedure ■ treatment following an accident that happened before your cover start date.

Core cover - Home Nursing

What's covered	What's not covered
<p>The services of a qualified nurse for skilled nursing care at home. For you to qualify for this benefit, all home nursing must</p> <ul style="list-style-type: none"> ■ immediately follow a period of in-patient treatment for a medical condition covered by the plan ■ be certified by your specialist as necessary for medical (not domestic) reasons ■ be skilled nursing care provided at your home, which would otherwise be provided in hospital as an in-patient ■ be given by a qualified nurse and carried out under the direction of your specialist. 	<ul style="list-style-type: none"> ■ home nursing following in-patient treatment for psychiatric and mental conditions ■ home nursing for a chronic condition ■ any charges for domestic or social reasons ■ frail care (e.g. care received in a convalescence or nursing home, respite care and domestic support that does not require a trained practitioner).

Other cover options

The following options are only available to you if they've been selected by your employer.

You are only covered for any cover options that show on your certificate of insurance. Please also refer to it for details of any limits that apply.

Out-patient Cover † (limits depend on the level of cover chosen)

What's covered	What's not covered
<p>Specialist consultations and diagnostic tests such as pathology, X-rays and ECGs undertaken as an out-patient</p> <p>Out-patient physiotherapy</p> <p>Important note: As with our hospital lists, we have agreed tariffs in place with a select network of physiotherapists across the country. Providing you go to a physiotherapist within this network, we'll cover each physiotherapy session in full (subject to any limits on your 'Out-patient cover') and we'll pay the provider direct.</p> <p>If you use a physiotherapist outside this network, then we'll only pay a set amount per session and you'll have to pay the provider direct yourself including making up any shortfall. You can find details of the amounts we'll pay if you go out of network by going to our website.</p>	<ul style="list-style-type: none"> ■ routine medical or dental checks ■ routine sight and hearing tests ■ medical aids or appliances (e.g. neck collars, splints and foot supports) ■ mobility aids (e.g. wheelchairs and crutches and external prostheses) ■ spectacles, contact lenses, hearing aids or cochlear implants ■ drugs or dressings that you take home ■ any treatment or tests ordered by your GP including diagnostic tests such as x-rays and blood tests ■ GP visits.

Out-patient diagnostics – full cover	
What's covered	What's not covered
<p>Out-patient diagnostic tests such as pathology, X-rays and ECGs are covered in full.</p> <p>Note: This option is available if your employer buys our 'Out-patient cover' but chooses to limit that cover. If they choose this upgrade option, it means that your out-patient diagnostic tests will be covered in full and won't count towards your 'Out-patient cover' limit. Instead, only your out-patient specialist consultations and physiotherapy will be subject to whatever limit shows on your certificate of insurance against the 'Out-patient cover' option.</p>	<ul style="list-style-type: none"> ■ routine medical or dental checks ■ routine sight and hearing tests ■ drugs or dressings that you take home ■ any treatment or tests ordered by your GP or therapist, such as physiotherapist ■ GP visits.

Psychiatric Cover † <i>(limits depend on the level of cover chosen)</i>	
What's covered	What's not covered
<p>In-patient and day-patient treatment in any psychiatric hospital on your chosen hospital list:</p> <ul style="list-style-type: none"> ■ accommodation, nursing, drugs prescribed on a ward, diagnostic tests and specialists' fees <p>Out-patient treatment including:</p> <ul style="list-style-type: none"> ■ specialist consultations, electroconvulsive therapy (ECT) and diagnostic tests ■ consultations with a clinical psychologist upon GP referral <p><i>Please also see 'Important information about your cover' paragraph 1.5</i></p>	<ul style="list-style-type: none"> ■ any treatment not under the control of a psychiatric specialist except for out-patient consultations with a clinical psychologist upon GP referral ■ consultations that aren't face to face (for example telephone consultations are not covered).

Therapies Cover † *(limits depend on the level of cover chosen)*

What's covered

The following therapies or consultations after referral by your **GP** or **specialist**:

- **chiropractic**
- **osteopathy**
- **chiroprody/podiatry**
- **acupuncture**
- **homeopathy**
- consultations with a **dietician** (maximum of two per **plan year**).

Please also see 'Important information about your cover' paragraph 1.7

What's not covered

- drugs or dressings that you take home
- medical aids or appliances (e.g. neck collars, splints and foot supports)
- mobility aids (e.g. wheelchairs and crutches)
- **treatment** following self-referral where you've not visited your **GP**, unless this has been agreed by us in writing in advance of the **treatment**.

Overseas Emergency Medical Expenses	
What's covered	What's not covered
<p>Medical expenses* †</p> <p>All reasonable charges for an emergency admission for in-patient or day-patient treatment at a medical facility overseas as a result of a sudden and unexpected illness or injury that arises whilst travelling outside the UK. Treatment must be undertaken by a qualified medical practitioner and in a recognised facility in the country in which it takes place.</p> <p>Reasonable additional accommodation costs and travelling expenses for one person required on medical advice to remain behind with a sick or injured insured person.</p> <p>Note: Cover is restricted to trips outside the UK of up to 90 days.</p> <p>* A £50 excess applies per claim</p> <p>Mondial Assistance runs a 24 hour emergency service on our behalf and are there to help you in the event of a serious illness or injury requiring emergency treatment. Their contact details can be found in your certificate of insurance if you have this cover.</p> <p>If you have any other current insurance plan that may also cover these costs then you must provide us with the full details of the other plan, including insurer name and address, plan and claim number and any other relevant information. We will then contact the other insurance company to ensure that we only pay our proportion of the claim; this may involve us sending your personal information regarding your claim to the other insurer.</p>	<ul style="list-style-type: none"> ■ if you've gone abroad in the knowledge that you might require medical treatment, or against medical advice ■ any illness or injury that arises after the 90th day of your trip ■ if you've travelled abroad after being diagnosed with a terminal condition ■ out-patient treatment including any treatment that would normally be carried out by a GP in the UK ■ out-patient drugs and dressings including drugs bought over the counter ■ treatment that would not ordinarily be covered under this plan if it took place in the UK ■ treatment that could have waited until you returned to the UK ■ claims arising from high-risk activities such as mountaineering, parachuting, hang-gliding, potholing, bungee jumping, skiing or snowboarding off the designated course (off-piste), scuba diving unless you have the recognised diving qualifications or are accompanied by someone with them. (This list is not exhaustive, so please contact us if you need more information).

Overseas Emergency Medical Expenses

What's covered

Repatriation/evacuation †

Repatriation expenses* (the cost of returning you home) if whilst travelling outside the **UK**:

- you have to go into **hospital** immediately as a direct result of a serious injury or sudden illness, and
- a doctor chosen by Mondial Assistance decides that, for medical reasons, you must be taken immediately to a **hospital** in the **UK**.

Evacuation expenses* (the cost of taking you to the nearest available and appropriate medical facility) due to a serious injury or sudden illness whilst travelling outside the **UK**.

* A **£50 excess** applies per claim

If you or an **insured dependant** die:

- the cost of transferring the body or ashes back to the **UK** (but not funeral and burial costs), or
- the cost of burial or cremation outside of the **UK**

Important notes:

- Mondial Assistance will decide which of repatriation or evacuation is the most appropriate response taking account of your medical condition and the nearest available medical facilities. Repatriation should only take place where the most appropriate and closest medical facility for treating your condition is in the **UK**.
- We will not be liable for any failure or delay in providing this repatriation or evacuation service for reasons that are beyond our control. This includes failure or delay caused by circumstances such as, but not limited to, mechanical breakdown or bad weather conditions, or where the country you're in prevents us from providing this service.

What's not covered

- if you've gone abroad in the knowledge that you might require medical **treatment**, or against medical advice
- for any illness or injury that arises after the 90th day of your trip
- if you've travelled abroad after being diagnosed with a terminal condition
- the costs of repatriation or evacuation that has not been approved and arranged by Mondial Assistance or any other individual or company acting on our behalf
- if the **treatment** needed would not ordinarily be covered under this plan if it took place in the **UK**
- if repatriation or evacuation was against medical advice
- claims arising from the high-risk activities stated in the previous cover section
- claims arising from travelling to a destination which, before the start of your trip, the British Government had recommended people shouldn't travel to (visit the Foreign and Commonwealth Office website at www.fco.gov.uk/knowbeforeyougo for up to date country information).

Private GP helpline

This is a 24-hour phone line giving you access to a doctor seven days a week, so you don't have to wait for an appointment with your **GP**. The doctor won't be able to prescribe medicine but can often work out what's wrong from your symptoms. If you need to visit your own **GP** afterwards, having that initial diagnosis is likely to speed things up. And if it's something serious, you should be able to get an emergency appointment more easily. To be referred for **treatment**, you need to see your own **GP**. Private GP helpline is only available to you if your company has chosen it and it shows on your certificate of insurance.

Employee Assistance Programme

At certain stages in life we may face emotional problems that can be hard to cope with, such as stress at work, marital difficulties, debt worries or bereavement.

In those instances, your Employee Assistance Programme can provide support, advice and expert assistance to help you through difficult times.

This service includes:

- Unlimited access to a 24-hour dedicated helpline providing debt counselling, legal and financial advice
- Confidential face-to-face counselling where required. (Up to six free sessions per **plan year**).

The Employee Assistance Programme is only available to you if your **company** has chosen it and it shows on your certificate of insurance.

Exclusions (what's not covered)

Below we've set out the exclusions that apply to this section of your plan. In addition, any consultations, complications or subsequent **treatment** related to these exclusions are also not covered. For ease of reference, we have divided the exclusions into the following categories:

- Medical conditions
- Treatments and tests
- General exclusions

Medical conditions

We will not pay for the following:

- a) If you or your **insured dependants** have a moratorium underwriting basis:

We will not pay for **treatment** of any medical condition or **related condition** which in the five years before your **cover start date** you:

- have received medical **treatment** for
- had symptoms of
- have asked advice on or
- to the best of your knowledge were aware existed.

This is called a 'pre-existing medical condition'.

However, subject to the plan terms and conditions, a pre-existing medical condition can become eligible for cover providing you have not:

- consulted anyone (e.g. a **GP, dental practitioner**, optician or therapist, or anyone acting in such a capacity) for medical **treatment** or advice (including **check-ups**), or
- taken medication (including prescription or over-the-counter drugs, medicines, special diets or injections),

for that pre-existing medical condition or any **related condition** for two continuous years after your **cover start date**.

For full details of how we deal with such conditions, please refer to Appendix 1 at the back of this plan called 'Your guide to our moratorium clause'.

- b) If you or your **insured dependants** have been **medically underwritten**:
- we will not pay for **treatment** of any medical condition we specifically exclude you or your **insured dependants** for as shown on your certificate of insurance. **Treatment** for any medical condition that you did not disclose on your health questionnaire when you should have done will also not be covered. Please refer to the section entitled 'Full medical underwriting' under 'Acceptance terms' on page 40 and to your certificate of insurance for further details.
- c) If you or your **insured dependants** have transferred from another insurer with a continued moratorium:
- we will not pay for **treatment** of any medical condition or **related condition** which is excluded under our moratorium rules (under 'Acceptance terms' on page 40) applied from when your cover first started with your previous insurer. Please see your previous insurer's certificate of insurance or other relevant documentation for details of your **cover start date** with them.
- d) If you or your **insured dependants** have transferred from another insurance plan with continued personal exclusions:
- we will not pay for **treatment** of any condition specifically excluded by your previous insurance plan. Please refer to the section entitled 'Continued personal exclusions' under 'Acceptance terms' on page 40 for full details.

Additional exclusions that apply under this medical conditions section are below.

We will not pay claims relating to:

- **treatment** of alcoholism, **drug abuse**, or any addiction, and **treatment** of any related medical conditions resulting from these
- **treatment** of any self-inflicted illness or injury, or any **treatment** related to them, or **treatment** arising from attempted suicide
- **treatment** of **chronic conditions** including investigations, regular monitoring or consultations with any healthcare professional. However, we will cover **treatment** of an **acute flare-up of a chronic condition** providing this is not part of the normal recurring nature of the condition

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- **treatment** for injuries that arise from taking part in **professional or semi-professional sport**
 - **treatment** to maintain your state of health or to monitor your health on a regular basis
 - **treatment**, including investigations and assessments, related to developmental problems and learning difficulties including but not limited to dyslexia, dyspraxia and behavioural problems such as 'Attention Deficit Hyperactivity Disorder' (ADHD)
 - **treatment** for myopia (short-sightedness), hypermetropia (long-sightedness), astigmatism or any other refractive error or **treatment** which results from, or is in any way related to, these conditions
 - **treatment** of sleep apnoea, snoring, insomnia or other sleep disorders or **treatment** which results from, or is in any way related to, these conditions
 - **treatment** for obesity, including surgery, or **treatment** which results from, or is in any way related to, this condition
 - **treatment** for deafness that arises as a result of any congenital abnormality, maturity or ageing. We will only pay for **treatment** for deafness that arises as a result of an **acute condition** diagnosed within the previous 12 months and after your **cover start date**
 - **treatment** to relieve the symptoms commonly associated with physiological or natural changes as a result of ageing e.g. menopause or puberty
 - **treatment** for complications arising from medical conditions or **treatment** not covered by us. This includes complications arising from experimental **treatment** or **treatment** received overseas
 - frail care such as care received in a convalescence or nursing home, respite care, and domestic support that does not require a trained practitioner.

Treatments and tests

We will not pay for the following **treatments**:

- the services of a **GP**
- **diagnostic tests** that have been arranged by anyone other than your **specialist**
- emergency admission to **hospital** and all immediate care associated with the emergency admission until the condition has been stabilised
- **treatment**, including surgery, to remove healthy or non-diseased tissue whether or not for psychological or medical reasons, including but not limited to breast reduction and treatment of ptosis (drooping) of the eyelid and/or brow
- cosmetic treatment, whether or not for psychological reasons, or any **treatment** that results from or relates to previous cosmetic treatment or reconstructive surgery. However, we will cover the initial **treatment** to restore function or appearance where this is needed as a direct result of an **accidental injury** or as a result of **treatment** for **cancer** that occurs after your **cover start date**. Any subsequent related **treatment** will only be covered if intended to cure an **acute condition**
- sex change/gender reassignment or **treatment** which results from, or is in any way related to, sex change/gender reassignment
- hormone replacement therapy
- dental treatment unless you have our dental cover as shown on your certificate of insurance
- regular or long-term dialysis in chronic or end-stage kidney failure
- organ transplants, stem cell therapy and bone marrow transplant, except where this is for the **treatment** of **cancer**
- **treatment** or drug therapy which, based on established medical practice in the **UK**, is considered to be experimental or unproven, or for which there is insufficient evidence of safety or effectiveness

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- any **treatment** using unlicensed drugs or the use of drugs outside the terms of their licence in the **UK**
 - **rehabilitation** following **treatment**, except in the circumstances detailed in paragraph 1.6
 - **treatment** that's given solely to provide relief of symptoms including psychological support, end of life or hospice care. However, we will cover end of life **treatment** to help relieve **cancer** symptoms or the side effects of **cancer treatment**. This includes **treatment** at home where it would otherwise require **in patient** or **day-patient treatment**.
 - any **treatment** for, related to, or arising from or as a consequence of:
 - male or female birth control including sterilisation and its reversal
 - any type of contraception
 - termination of pregnancy
 - pregnancy or childbirth, except the conditions shown in your benefits table
 - investigations into or **treatment** of infertility
 - investigations into or **treatment** of impotence or other sexual dysfunction
 - any form of human-assisted reproduction
 - any **treatment** received within three months of birth by a dependant born as a consequence of any form of human-assisted reproduction
 - oral surgery, except those procedures shown in your benefits table
 - anything to do with routine, precautionary or preventive examinations, dental **check-ups** (unless you have our dental cover as shown on your certificate of insurance), routine hearing and sight tests, vaccinations, screenings (including screenings of familial conditions) or preventive **treatment**
 - any **treatment** provided by a **specialist**, therapist or complementary medicine practitioner who is not recognised by us as having specialised knowledge of, or expertise in, the **treatment** of the disease, illness or injury or who is not a member of their recognised professional body or Health Professions Council (HPC).

General exclusions

In addition to the specific exclusions detailed, the following general exclusions apply. We will not pay claims relating to:

- **treatment** arising from nuclear or chemical contamination, war, invasion, act of foreign enemy, hostilities (whether war is declared or not), civil war, riot, civil disturbance, wilful violation of the law, rebellion, revolution, military force or coup, act of terrorism
- **treatment** received after the period covered by any premium or after the plan has been cancelled
- **treatment** that is available under a cover option that you do not have. Please refer to your certificate of insurance to check which cover options you have
- extra accommodation costs for going into **hospital** early or leaving late because of your or your **insured dependant's** domestic circumstances or where there is no required **treatment**
- **treatment** received outside the **UK** unless you have either our emergency overseas benefit or our travel cover as shown in your certificate of insurance.

Important information about your cover

1.1. Cover limits

Any cover limits will show in your certificate of insurance and, unless stated otherwise, apply per person per **plan year**.

1.2. Excesses

Any **excess** due under your plan will show on your certificate of insurance. An **excess** can be payable either 'per claim' or 'per person per **plan year**' and your certificate of insurance will show you which one applies.

We will deduct the **excess** from the first invoice we pay (and the next invoice if any **excess** still remains) and you will then need to pay the **excess** amount to the relevant person, **hospital** or other facility that provided your **treatment**.

Unlike most other health insurers, if an **excess** is paid towards eligible **treatment** costs that are normally subject to a limit, we will not reduce the benefit available by the **excess** amount. For example:

'Out-patient cover' limit for a plan year	£500
You incur out-patient costs of	£300
You pay an excess of	£100
We pay the balance of	£200
The benefit remaining for the plan year is still	£300

Note: the above example is an illustration only; please refer to your certificate of insurance to check if you have this cover and, if so, what limit applies.

Even if the **treatment** costs are less than the **excess**, you should tell us so we can calculate how much of the **excess** there is left to pay. This will be to your advantage.

The **excess** doesn't apply to:

- NHS **in-patient** and **day-patient** cash benefit
- Childbirth cash benefit
- Dental cover (if you have this option)
- Travel cover (if you have this option - but a £50 **excess** applies to some sections of this cover)
- Claims from your Personal Health Fund (if you have this benefit).

1.3. Treatment at a hospital not on your list – what you will have to pay

We offer a range of hospital lists to choose from. This includes two London upgrade options. **Hospitals** on these upgrade options are available for an increased premium.

Please note that you must go to a **hospital** on your selected list for any **treatment** that you need in order for your eligible costs to be covered. We would advise that you always check on our website for the latest **hospitals** available to you based on your selected hospital list. If you decide to use a **hospital** not on your list for **treatment** that is otherwise eligible under this plan, then we will not cover your costs in full. Instead, you will have to pay 40% of the costs of your **in-patient, day-patient** or **out-patient treatment** (excluding your **specialist's** fees).

1.4. Intensive and high dependency care

We will pay for **critical care** where it is part of the expected post-operative management of **treatment** of an **acute condition**. We will pay for unexpected care in a private **hospital** providing the following conditions are met:

- it follows an elective, non-emergency admission
- it is provided in a dedicated **critical care** area, and
- it is the most appropriate setting for such **treatment**.

We do not pay for unexpected **critical care** in an NHS hospital under any circumstances, nor for expected critical care following an emergency admission. We do not pay for any level of **critical care** which is not medically necessary for the condition being treated.

1.5. Psychiatric Cover

Claims for psychiatric **treatment** (where covered under your plan) are managed by us through appointment of a case manager. Please note that due to the nature of psychiatric illness it may be that over the course of **treatment**, the condition will be deemed to be chronic (long-term). Where this happens, we will always give you reasonable notice before withdrawing cover so that you can make alternative arrangements.

1.6. Rehabilitation

Cover is available for **rehabilitation** following a stroke or injury. The **rehabilitation** must be integral to eligible **in-patient treatment**, should start no more than two months after initial diagnosis or date of injury, will normally be covered for 21 days only and will be managed within our guidelines for **chronic conditions**. To be eligible a **specialist** should make the referral to a rehabilitation unit.

1.7. Therapies Cover

If you have this benefit and want to claim then, to be eligible for cover, the therapy must be used for **treatment** of an **acute condition** following referral by a **GP** or **specialist**. All practitioners must have adequate experience and indemnity insurance and must be registered with the appropriate authority and be a member of a speciality organisation. Our list of criteria for entry for all **providers** is available on request and on our website.

1.8. Childbirth Cash Benefit

To claim this benefit you must provide us with a copy of the birth certificate and request the payment of benefit within six months of the birth.

1.9. Private Ambulance

Use of an ambulance is covered for private transfers between **hospitals**, whether NHS or private. This use is limited to paid services provided by independent companies or the NHS. It is limited to medically necessary transfers where there is a reasonable medical need for the action to be taken. Transfers for non-medical reasons will not be covered.

1.10. Parental Accommodation

This cover is to enable one insured parent to stay in the same **hospital** as your insured dependent child (under age 14) when your child is admitted as an **in-patient** to a private **hospital** or an NHS private ward within an NHS Private Patient Unit (PPU). Paediatric conditions are mainly treated in NHS hospitals, though some private **hospitals** still provide **treatment**. If your **insured dependant** goes to an NHS hospital for eligible **in-patient** or **day-patient treatment**, they are eligible for the NHS hospital cash benefit.

1.11. Cancer Cover

As a general rule, we would expect the **treatment** of **cancer** to follow any guidance issued by the National Institute for Health and Clinical Excellence (NICE). However, we will cover new drugs or other **treatments** where, even though they may not have been reviewed or recommended by NICE, there is adequate evidence of their effectiveness.

For more detailed information about our cover for **cancer treatment**, please refer to *Appendix 3* on page 75.

1.12. Experimental treatment

Our plan does not cover drugs and **treatment** that are not considered to be established medical practice in the **UK** or for which there is insufficient evidence of safety or effectiveness. This includes drugs that are used outside the terms of their licence or **treatment** that has not been reviewed and approved for general use in the NHS by the National Institute for Health and Clinical Excellence (NICE). However, we may consider covering experimental **treatment** where this is part of a properly controlled clinical trial.

If you decide to undergo drug therapy or **treatment** that we consider experimental, and it is not part of a clinical trial that we have agreed to cover, then we will only make a contribution towards the costs based on what we would have paid for the nearest equivalent established **treatment** for your condition at a **hospital** on your hospital list. However, we will not:

- pay any costs if the **treatment** would in any event be excluded under the other terms and conditions of this plan
- pay more than the cost of the experimental **treatment** if this is lower than the cost of its nearest equivalent established **treatment**
- pay for any further established **treatment** that you could have had instead
- pay for the **treatment** of any complications arising from the experimental **treatment** or for any further **treatment** you might need because of the experimental **treatment**
- pay for any costs if there is no alternative established **treatment**.

Vitality Cashback

To reward you for taking part in our Vitality programme, and improving your status, we give you a cash reward after every third **plan year** that you've been covered under this plan based on your Vitality status in each of the preceding **plan years**. The better your Vitality status, the greater the cash reward you'll get, as follows:

Vitality status at each annual renewal date	Cashback earned each year
Bronze (Providing you have completed your Health Review and not made a claim)	£25
Silver	£50
Gold	£75
Platinum	£100

At the end of the third year, and providing your **plan** renews with us for the following plan year, we'll pay you the total amount earned over those three **plan years**.

Important notes about Vitality Cashback

- Vitality Cashback is only paid six weeks after your employer renews your plan for the following **plan year** and providing you are still an **insured member** at that time
- If your plan lapses or is cancelled for any reason, then no cashback will be paid
- Vitality Cashback is only payable to the **insured member** based on their own Vitality status in each of the three preceding **plan years**. If two employees are partners and are covered on the same certificate of insurance, then only the one named as the **insured member** can earn Vitality cashback
- If you are on Bronze status at the end of a **plan year**, you must have completed your Health Review and not made a claim in order to be eligible for Vitality cashback

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- We will use your recorded Vitality status as at your **annual renewal date** each year for the purpose of calculating the Vitality Cashback; it's your responsibility, and is in your best interests, to record your point scoring activities to ensure you get the maximum benefit from our Vitality programme
 - If you join partway through a **plan year**, then any cashback entitlement you earn for that year will be proportionate based on the exact number of days you are covered that year.

Vitality status

There are 4 statuses; Bronze, Silver, Gold and Platinum. Everyone starts at Bronze and your Vitality status is then determined by the points you build up throughout the **plan year**, through activities ranging from exercise and healthy eating to health screens and regular **check-ups**. The Vitality status you achieve by the end of a **plan year** will then remain for the whole of the next **plan year**, unless you improve your status.

You can improve your status by achieving the required number of points to move from one status to the next; we call this the 'Vitality status threshold.' For example, currently you need 800 Vitality points to reach Silver status and you would need to increase this to 1,600 points to achieve Gold status. When there are two adults on a **plan** the thresholds are doubled, and so on.

Your Vitality status can go down at each **annual renewal date** if the number of Vitality points you earn that **plan year** isn't enough to maintain the status previously achieved. Vitality status can also change midway through the **plan year** as new adult dependants are added or removed.

Vitality

This section tells you a little more about our Vitality wellness programme.

Our reason for creating the Vitality programme is simple. If you stay healthy by exercising regularly, eating well and not smoking, you could add years to your life. And that's why we believe health insurance shouldn't only benefit people that need to claim.

Vitality is core to our Business and Corporate Healthcare plans. This means everyone has access to our proven wellness programme which includes activities and partner discounts to help you get and stay healthy for less.

There are discounts with our health partners and half price health screens, as well as useful tools to help you understand and monitor your health, and set goals to improve it. As you take part in the programme, you'll earn Vitality points which count towards your Vitality status, helping you to see your progress. Everyone starts at Bronze and can move up to Silver, then Gold and finally Platinum.

We've also focused on two key areas that can help you improve your health - exercising and eating well. So we give you a 50% discount on the full individual monthly gym membership fees with Virgin Active and LA fitness and we'll support your efforts to eat well. When you buy certain healthy foods from Sainsbury's you will get five times the usual number of Nectar points.

Vitality Plus makes looking after your health more rewarding – the more you participate and improve your Vitality status the higher your discounts will be with our range of reward partners.

More about Vitality

Here's some more information about Vitality but for full details on how it all works and the benefits you can enjoy, please visit our website and log onto the Member Zone.

There are four statuses, Bronze, Silver, Gold and Platinum. Everyone starts at Bronze and your Vitality status is then determined by the points you build up throughout the **plan year**, through activities ranging from exercise and healthy eating to health screens and regular **check-ups**. The Vitality status you achieve by the end of a **plan year** will then remain for the whole of the next **plan year**, unless you improve your status.

You can improve your Vitality status by achieving the required number of points to move you from one status to the next; we call this the 'Vitality status threshold'. For example, currently you need 800 Vitality points to reach Silver status and you would need to increase this to 1,600 points to achieve Gold status. When there are two adults on a plan the thresholds are doubled, and so on.

Your Vitality status can go down at each **annual renewal date** if the number of Vitality points you earn during that **plan year** isn't enough to maintain the status you previously achieved. Vitality status can also change midway through the **plan year** as new adult dependants are added or removed. **Insured members** and **insured dependants** must be 18 or over to benefit from Vitality.

How Vitality can change

This section explains how and why our Vitality programme can change at any time.

1. Our Vitality programme naturally changes over time as new opportunities and technologies arise. It is also dependent on our relationship with third party providers and the range of services they offer.
2. We may change the way we award points and/or the eligible activities in the Vitality programme and the Vitality status you may achieve as a result. We may also change our Vitality partners from time to time and the incentives we offer. There may be instances where other aspects of the Vitality programme, such as particular benefits, may be significantly enhanced, changed or withdrawn.

3. These changes may occur if our Vitality partners offer additional services or become unable to maintain their levels of service to us, or where we add new Vitality partners to the programme. Vitality changes may also be required to prevent the fraudulent use of benefits. Revisions may be required as a result of other factors beyond our control.
4. Vitality benefits are expressed in one of two ways: as a straightforward price, or as a percentage discount off a provider's standard price. We reserve the right to increase the former during the **plan year**. If we do need to increase these prices, we will increase them for all our members at the same time, to avoid any confusion. Any price increases will only occur once during a **plan year**. No price increase shall exceed the amount equal to the change in the Consumer Price Index (since our last price increase for that benefit) as calculated against the Bronze price (or the price paid by all members if there is no difference in price according to Vitality status).

For example, if the Bronze price (or standard price, if applicable) for a particular benefit is £100, and the CPI increases 3%, the maximum price increase for any Vitality status shall be £3. Therefore, if the Platinum price for that particular benefit is £10, the most someone on Platinum status would pay is £13.

5. The cost of Vitality benefits expressed as a percentage discount off a provider's standard price may vary during the year if that provider changes its standard price. For example, the current discount on our health screens is 50%. If the current standard price is £40, the cost to you would be £20. If the standard price was increased to £50, the cost to you would be £25.
6. We will usually tell you about any changes to the Vitality programme, including any price increases, at least six weeks before the changes take effect, unless we're unable to do so due to factors outside our control. If your employer is not satisfied with the changes, they may cancel your plan in line with the cancellation provisions in section 5.6 (page 52). However, please note that you may still be subject to the notice period of any relevant Vitality partner and to any other relevant terms and conditions of that Vitality partner.

7. Please note that the previous clause refers just to changes to the Vitality programme made within the **plan year** and does not prevent us from applying changes and price increases at each **annual renewal date**.
8. New adult dependants or partners who join during a **plan year** will alter the Vitality status thresholds but can immediately participate in Vitality activities and earn Vitality points up to the renewal of your plan.
9. **Insured dependants** or partners can be taken off the plan throughout the **plan year** but you must give us 30 days advance notice. Anyone leaving the plan before the end of the **plan year** will not be entitled to any share of benefits they may have earned during that **plan year**. All of an **insured member's** Vitality benefits will cease when their cover ends subject to the notice period of any relevant Vitality partner. Also, all Vitality points they've earned will be removed from the plan and Vitality status thresholds will be adjusted accordingly, and result in a change in Vitality status.
10. There will be no refund in respect of any Vitality activities or Vitality points earned once a plan has been cancelled.

Note: Your employer may also have upgraded your plan to include a Personal Health Fund (PHF) or Vitality-linked excess (available for schemes of 10 or more members). Your certificate of insurance will show if you have these and, if you do, you should refer to Appendix 4 called 'Vitality' for more information.

Acceptance terms

When you joined PruHealth, you were accepted on one of the following methods of underwriting. Your certificate of insurance will confirm which method applies.

2.1. Full medical underwriting

Before starting your cover, you completed an application form in which you gave us details about your medical history and that of any **insured dependants**. This information and any additional information supplied by your **GP** was then assessed by our medical underwriters. Medical conditions and **related conditions** you had in the past that are likely to need **treatment** in the future are not covered and are shown on your certificate of insurance.

If you have failed to provide full and accurate information in answer to the questions asked on application, this may mean that we cannot cover your claim.

2.2. Moratorium

Before starting your cover, you did not have to answer any health questions on your application form. Therefore, each claim is assessed on the information provided by you and your **GP** when you claim. We will not cover **treatment** of any medical condition or **related condition** which is excluded under the terms of our moratorium clause, as set out in the 'Exclusions (what's not covered)' section on page 23.

You can find more information about how the moratorium works in practice by referring to Appendix 1, 'Your guide to our moratorium clause' on page 66.

2.3. Continued Personal Medical Exclusions (switch)

This is where you've been covered by another insurance plan and you applied to join us on the basis of continuing with the personal exclusions that applied to you and your **insured dependants** with that other insurance plan. You completed a short health questionnaire and we accepted you on one of the following bases:

Where you were previously medically underwritten:

- either exactly the same personal exclusions that applied to you and your **insured dependants** under your previous insurance plan continue to apply under this plan, or

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- the same personal exclusions applied to you and your **insured dependants** by your previous insurance plan continue to apply under this plan but additional personal exclusions imposed by us also apply.

Where you were previously subject to a moratorium clause:

- either our moratorium clause applies but backdated to when your cover first started with your previous insurer, or
- our moratorium clause applies backdated to when your cover first started with your previous insurer but additional personal exclusions imposed by us apply from your **cover start date** with us.

Please see the copy of your certificate of insurance for details.

Where you were previously covered on a medical history disregarded basis:

This means no personal medical exclusions applied to your previous plan and this continues under this plan. However, the exception to this is if you were asked to complete a switch application form, in which case, depending on your answers, we may apply personal medical exclusions. If this applies to you then any exclusions will be listed in your certificate of insurance.

Please note that the benefits, terms and conditions of this plan may be different from those of your previous plan.

2.4. Medical history disregarded

If your certificate of insurance states 'medical history disregarded', this means that there are no personal exclusions applied to your plan but this does not affect the remaining terms and conditions listed in this document, which will continue to apply.

2.5 Reviewing personal exclusions

Personal exclusions can, in some cases, be reviewed in the future if you ask us to do so within 30 days of your **annual renewal date** but if we need to obtain any medical evidence you will have to pay for this. However, we will not remove any exclusion for a **chronic condition**.

Claims conditions

3.1. The cover

The overall intention of this plan is to provide you with cover for access to prompt private medical care for **acute conditions** and to meet the eligible costs of **treatment** provided by a **specialist** for these **acute conditions**. **Acute conditions** often have a rapid onset and respond quickly to **treatment**. There should not be a need for prolonged care once recovery is complete.

You will see from the section headed 'Exclusions (what's not covered)' on page 23 that we do not pay for **treatment of chronic conditions**. Therefore, once it is clear that a medical condition is of a chronic nature, we will stop paying **treatment** costs.

For example, we will not pay for routine follow-up consultations or for the monitoring of medical conditions such as diabetes, multiple sclerosis and other long-term conditions. However, if you suffer an **acute flare-up of a chronic condition**, we will pay the eligible costs of the **treatment** required to return you to your state of health immediately before the **acute flare-up**.

For more information about **chronic conditions**, please refer to *Appendix 2* at the back of this document called 'Chronic conditions information'.

3.2. Your responsibilities

These are conditions of the insurance you'll need to follow in order to make a claim.

- You must obtain authorisation from us for any claim before starting **treatment**. This is the best way of ensuring that the **treatment** you need is covered under this plan. We will confirm whether or not the claim is eligible for benefit in writing
- More often than not we will be able to take claim details over the phone and authorise your proposed **treatment** at the same time providing it's eligible and taking place in a **hospital** on your list
- Sometimes we may need you to send us a fully completed claim form to help us assess your claim. We will not pay fees charged by a medical practitioner for completing a claim form. If **treatment** continues for a long time, we may need further medical evidence

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- We may need your consent to obtain a medical report or a copy of your NHS medical records from your **GP, specialist** or another practitioner involved in your **treatment**, in accordance with your rights under the Access to Medical Reports Act 1988. If you do not give your consent, we may not be able to assess and pay your claim. If we need to obtain a medical report to help us assess a claim, we will pay for that report
 - If you are going to have **treatment in hospital**, please always check on our website that the **hospital** you intend going to is still available to you. You should also check that your **specialist** can treat you at the **hospital** you choose
 - Unless specifically confirmed by us, you may only use the **hospitals** shown on your selected hospital list. We reserve the right to amend the list at any time, at our discretion, but this will not affect your cover if you're already receiving **in-patient** or **day-patient treatment** in a **hospital** that was on your list when that **treatment** started. We may need to amend the list if, for example, we are unable to reach agreement with an individual **hospital**, or group of **hospitals**, on their proposed charges. We will keep our hospital lists up to date on our website and reflect any changes there.

3.3. If you're covered by another plan

If you have any other current plan that covers the same costs as we do, you must provide us with full details of the other plan, including insurer name and address, plan and claim number and any other relevant information when you first submit your claim. We will then contact the other insurance company to ensure that we only pay our proportion of the claim; this may involve us sending your personal information regarding your claim to the other insurer.

3.4. If somebody else has caused you to claim

If you, or an **insured dependant**, are claiming under this plan for eligible **treatment** for an illness or injury caused by somebody else (a 'third party'), you must tell us as soon as possible and supply us with all the relevant details of that third party.

If you are then pursuing a personal claim for damages against the third party, you must provide us with the full name and address of the solicitor handling the action. We will then contact the solicitor to register our interest and seek to recover our own costs, plus interest, in addition to any damages that you may recover or be awarded.

If we choose, we also have the right in your name but at our expense to:

- take over the defence or settlement of any claim
- start legal action to claim compensation from a negligent third party
- start legal action to recover from any third party payments that have already been made by us.

If you, or an **insured dependant**, are able to recover from the third party (whether or not through legal action) compensation that includes any **treatment** costs we've paid, you must repay that amount to us. Any interest that you may also have been awarded that relates to the recovered **treatment** costs is also payable to us. If you only receive a proportion of your claim for damages then you should repay to us the same proportion of our costs.

3.5. If we pay treatment costs outside the terms of your cover

If we agree to pay **treatment** costs that aren't eligible under the terms of your cover with us, then any payments we make will still be subject to any **excess** or benefit limits that apply. The fact that we've made these payments once does not mean we will make them again in the same or similar circumstances.

3.6. General claims conditions

- Any money paid to or by us will be in pounds sterling.
- We will not add interest to any money paid under the plan.
- We have arrangements in place with many of the **hospitals** on our lists that enable them to bill us direct for eligible **treatment**. Where this is the case, we prefer to pay money direct to the **hospital** or person who provided your **treatment**.
- If you do receive any invoices for **treatment** covered under this plan then these should be sent to us within six months of your **treatment** to be eligible for payment, unless there is a good reason why you can't do this.
- If you have already paid for your **treatment**, then you will need to provide us with a receipted invoice and we will then reimburse you for any eligible costs. If you die after paying for your **treatment** but before reimbursement to you, we will reimburse the executors of your estate.
- If an **excess** applies under your plan, we will deduct this amount from the first invoice we pay (and the next invoice if any **excess** still remains). We will tell you when we've done this and you will then need to pay the **excess** amount to the relevant person, **hospital** or other facility that provided your **treatment**.

General conditions

These are the general conditions that apply to this plan. There are other conditions that specifically relate to the claims process that you must follow and these are shown within the 'Claims conditions' section on the previous page.

4.1. What we expect from you

It is your responsibility to:

- inform us if you or any **insured dependant** are no longer resident in the **UK**
- inform us of your new address if you move house
- inform us of your new contact details such as telephone numbers and email address if they change.

4.2. Plan conditions

We have the right to alter the terms of your plan at each **annual renewal date**, including premiums rates and cover, but we will always give reasonable notice of any changes. Your plan will only be changed at an **annual renewal date** unless the legal, regulatory requirements and/or tax treatment applying to your plan change, or in accordance with our rights as expressed in the section called 'Our right to cancel your plan'. This is with the exception of your hospital list and our Vitality programme, which we may amend at any time. For more information about Vitality please read the separate section on pages 36-39.

We do not accept proof of posting an application form, claim form or premium payment as proof that we have received it.

Any changes to your cover we have issued previously will remain in force at each **annual renewal date** unless stated otherwise.

4.3. Your certificate of insurance

Your certificate of insurance should be read alongside these terms and conditions. It will list any other **insured dependants** that we have agreed to cover. The section 'Your cover explained' will show the specific cover options that apply to you, along with any limits where applicable. Any special terms to your plan will also be shown.

We will send you a new certificate of insurance at renewal each year. It's your responsibility to ensure that your personal details are accurate and to let us know immediately if anything needs correction.

4.4. Your rights under the contract

The contract of insurance for this plan is between the **company** and us. This means that your rights as an **insured member**, and those of your **insured dependants**, are limited to the following:

If you or your **insured dependants** make a claim, then in relation to your claim you are entitled:

- to receive information about the progress of that claim directly from us, or
- to enforce the terms of the plan.

But you or your **insured dependants** are not entitled:

- to begin legal proceedings against the **company** or us under the contract of insurance until you or your **insured dependants** have exhausted our standard claim and appeal process and have referred the matter to the Financial Ombudsman Service for review, or
- to negotiate the terms and provisions of the plan directly with us.

We will discuss renewal terms and other matters of administration only with the Group Secretary and not with any individual **insured member**.

4.5. Dishonesty/fraud

We believe our customers are honest, and the contract between us is based on mutual trust. However, dishonest or fraudulent insurance claims are occasionally made. Where dishonesty or fraud (which includes exaggeration) is detected, claims may not be paid and we may refer the matter to the Police for criminal prosecution. This plan may be rendered invalid and we may take other action consistent with our legal rights.

If any claim is in any respect dishonest or fraudulent or if any dishonest or fraudulent means or devices are used by you, any member of your household or anyone acting on your or their behalf to obtain benefit under your plan, then all benefits under your plan may be lost and you may have to return to us any payments already made as a result of any dishonest or fraudulent actions.

PruHealth is involved in a number of initiatives to detect and prevent insurance fraud. If a fraud is suspected, we may exchange information about you with other insurance companies, fraud prevention agencies and the Police.

4.6. The law and language applicable to this plan

Your plan is bound by English law and comes under the jurisdiction of the **UK** courts. The language used in these terms and conditions and any communications relating to them will be in English. The contents page and any headings are for convenience only and do not form part of the plan itself and nor do they affect its construction.

If you have any queries about your plan, please speak to your Group Secretary, or call your customer services team who will be happy to help you.

4.7. Our liability under this plan

Our liability under this plan is limited to paying for **treatment** or services in respect of eligible claims under this plan. The choice of provider of the **treatment** or services ("provider") for which you are claiming under this plan is your responsibility. We make no representations or recommendations to you or any of your **insured dependants** regarding the availability and standard of any **treatment** or services offered or provided by any provider.

We will not be held liable to you or any **insured dependant** for any loss, harm or damage of any description resulting from lack of availability or from a defect in the quality of any **treatment** or service offered or provided by such provider. This plan represents the whole and only agreement between you and PruHealth relating to the provision of private medical insurance.

We use Vitality partners to offer services and activities relating to the Vitality programme. While these companies are carefully selected, we cannot be held liable for any loss or harm to you or any **insured dependants** arising from any act or omission on the part of a Vitality partner, or as a result of using any service or product provided by a Vitality partner.

Membership

5.1. Who can be covered under this plan?

Subject to the agreement of the **planholder**, the following people may join this scheme:

- any employee (including any director, partner or owner) over the age of 16 providing they **meet** the eligibility criteria agreed with the **planholder**;
- the **insured member's** husband, wife or partner, who live at the same address as the **insured member**
- the **insured member's** children (including adopted children) providing they are under the age of 21 when they first join (they may stay on the scheme after age 21 but will be charged an adult rate on our Business Healthcare plan. On our Corporate Healthcare plan, they will continue to be classified as children and charged at an agreed child rate). You can add up to eight children on your plan

An **insured member** person must live in the **UK** for at least 180 days in each **plan year** and must be registered with a **UK GP** who holds their full medical records.

Our Worldwide Travel and Overseas Emergency Medical Expenses cover is only available to members providing they are under 65 when they join the plan.

An **insured member** person is only eligible for cover if they are not employed in the following occupations:

- working offshore in the extraction/refinery of natural/fossil fuels
- **professional or semi-professional sports** for which a salary, sponsorship, or a benefit in kind is received
- armed forces personnel.

If any person applying to join this plan already has cover with another insurer, we recommend they do not cancel that cover until we have confirmed in writing that we have accepted their application.

5.2. Adding more dependants to the plan

Your (the **insured member's**) husband, wife or partner and dependent children may apply to join at any time during a **plan year** subject to agreement from your Group Secretary. The appropriate application form will need to be completed and returned to the Group Secretary so that they can send it to us. If we accept your dependants, we will confirm to the Group Secretary their **cover start date** and send you a revised certificate of insurance detailing any special terms that may apply.

5.3. Adding newborn babies

If you add a child to the plan as an **insured dependant** within 30 days of their birth, by completing the relevant form, then as long as the parent has been an insured person for at least 10 months before the birth, and the child is added within the first 30 days of their birth, we will not apply the exclusion for pre-existing medical conditions or require them to be **medically underwritten**.

5.4. If you (the insured member) die

If you die, cover for any insured dependants will automatically end at midnight on the date of your death. Your insured husband, wife or partner will be allowed 30 days to apply to continue their cover with us on an individual basis providing they're aged 65 or under and have been insured under your **company** plan for at least two continuous years (this can include cover with a previous insurer if your scheme has switched to us). Providing they meet those criteria and they join within that 30 day period, then they can continue with the same **medical underwriting** terms that applied under this plan. Insured dependent children can also continue their cover on the same basis. Cover must be continuous and any existing special terms, such as personal exclusions, will continue to apply. They must meet the eligibility criteria for the new plan and it should be noted that the benefits, terms and conditions may be different from those of this plan.

If they are aged 66 or over at the date on which cover would need to continue, they will have to complete a health declaration about their medical history. If they can't meet the requirements of the declaration then continuation of cover will not be available and they will have to apply for a new plan with new underwriting terms.

5.5. If you become divorced or separated

If you (the **insured member**) have married or family cover and you become separated or divorced, your husband, wife or partner will no longer be eligible to be included as an **insured dependant** on this plan. You must inform us that you have become separated or divorced. Your husband, wife or partner may apply, within 30 days of the date of divorce or separation, to continue their cover with us on an individual basis and with the nearest equivalent benefits providing they're aged 65 or under and have been insured under your company plan for at least two continuous years (this can include cover with a previous insurer if your scheme has switched to us). Providing they meet those criteria and they join within that period, then they can continue with the same **medical underwriting** terms that applied under this plan. Cover must be continuous and any existing special terms, such as personal exclusions, will continue to apply. They must meet the eligibility criteria for the new plan and it should be noted that the benefits, terms and conditions may be different from those of this plan.

If they are 66 or over at the date on which cover would need to continue, they will have to complete a health declaration about their medical history. If they can't meet the requirements of the declaration then continuation of cover will not be available and they will have to apply for a new plan with new underwriting terms.

5.6. If your company plan is cancelled or you leave the company

If your **company** plan is cancelled for any reason, or if you leave the **company**, then cover for you and your **insured dependants** will end on the cancellation date, or on your leaving date, whichever is the earlier.

Once your cover under this plan ends, no further benefit will be payable for **treatment** received after that date. This will be the case even if:

- the claim originally started before the cover ended, or
- you and/or your **insured dependants** are in the middle of **treatment**, or
- you and/or your **insured dependants** have pre-notified us of further **treatment** required

5.7. How you can continue your cover with us when you leave the company

Providing you contact us within 30 days of leaving your **company**, we may offer you the opportunity to continue your cover with us on an individual basis and with the nearest equivalent benefits, providing you (and your insured husband, wife or partner if applicable) are aged 65 or under and have been insured under your **company** plan for at least two continuous years (this can include cover with a previous insurer if your scheme has switched to us).

Providing you meet those criteria you can continue on the same **medical underwriting** terms that applied under this plan. You must meet the eligibility criteria of the new plan and it should be noted that the benefits, terms and conditions of your individual cover may be different from those of this plan. Cover must be continuous, starting from the day after your cover ends under this plan, and any existing special terms, such as personal exclusions, will continue to apply. If you do not contact us within 30 days, any subsequent individual plan will start from a current date and we may not cover pre-existing medical conditions and in some circumstances we may be unable to offer cover.

If you or your insured husband, wife or partner are aged 66 or over at the date on which cover would need to continue, then you/they will have to complete a health declaration about your/their medical history. If the requirements of the declaration can't be met, then continuation of cover will not be available and you/they will have to apply for a new plan with new underwriting terms.

We will only offer continuation cover to you and, where applicable, your **insured dependants**, if you are leaving the employment of the **planholder**.

We do not offer continuation of cover to **insured dependants** unless you also require and are eligible for continuation cover.

Please note that it is the responsibility of you (the **insured member**) to contact us to arrange continuation cover.

Definitions

These definitions are shown in bold print throughout these terms and conditions and have the same meaning wherever they appear. If you have any difficulty understanding any part of the terms and conditions, please contact us.

Accidental injury

An injury directly caused by something accidental, outside the body, violent and visible. It does not include sickness, disease or any naturally occurring or deteriorating condition.

Acupuncture

A type of alternative medicine that must be carried out by a member of the British Acupuncture Council, or the Acupuncture Association of Chartered Physiotherapists, or by a medical practitioner who holds a Certificate of Basic Competence issued by the British Medical Acupuncture Society or a Diploma of Medical Acupuncture.

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.

Acute flare-up of a chronic condition

A sudden and unexpected deterioration of a **chronic condition** that is likely to respond quickly to **treatment** that aims to restore you to your state of health immediately before suffering the acute flare-up. For example we would cover eligible surgery following a heart attack that resulted from chronic heart disease. Just to be clear, this does not include deterioration of a **chronic condition** where this is part of the normal progress of the illness or recurring relapses of a **chronic condition**.

Annual renewal date

The date, 12 months after the **plan start date**, and each anniversary after that date.

Cancer

A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Check-up

A consultation with, or a visit to, any medical practitioner about any medical condition or any signs and symptoms of a medical condition.

Chiropody/podiatry

Diagnosis and treatment of disorders, diseases and deformities of the feet by a chiropodist/podiatrist. **Treatment** must be given by a practitioner who is registered with the Health Professions Council and recognised by us.

Chiropractic

A type of complementary medicine that must be carried out by a member of the General Chiropractic Council.

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 psychologist

A clinical psychologist is a mental health professional trained in the diagnosis and psychological **treatment** of mental illness, and who uses psychological techniques, rather than medication to treat mental illness.

PruHealth recognises clinical psychologists who are registered with the Health Professions Council.

Company

The employer who has agreed with us to operate a scheme for employees, paid for by the employer.

Cover start date

The date on which each **insured member's** cover starts, as shown on your certificate of insurance.

Critical care

Any care given in an Intensive Care Unit, Intensive Therapy Unit, Coronary Care Unit, High Dependency Unit, Paediatric Intensive Care Unit, Neonatal Intensive Care Unit, Special Care Baby Unit or similar level of care, wherever provided, is considered critical care.

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.

Diagnostic tests

Investigations, such as x-rays or blood tests, to find or to help to find the cause of your symptoms.

Dietician

A registered dietician who uses the science of nutrition to help in the **treatment** of medical conditions and to promote good health.

Drug abuse

The taking of any non-prescription drug, substance or solvent, or misuse of a drug prescribed by a **GP** or **specialist**.

Excess - per claim

Please refer to your certificate of insurance to see if this excess applies to you.

The maximum amount you will have to pay each time you or your **insured dependants** make a new claim for **treatment** covered by this plan. If **treatment**

for the same condition has gone on for more than a year, we will treat it as a new claim for any further **treatment** after the anniversary of the claim and a further excess will be applied.

Excess - per plan year

Please refer to your certificate of insurance to see if this excess applies to you.

The first amount which must be paid by you before we make any payment for **treatment** covered by this plan. Only one excess is payable in each **plan year** for each **insured member**. This excess resets at the beginning of each new **plan year**.

General practitioner (GP)

A medical practitioner who is registered and licensed with the General Medical Council in general practice.

Home nursing

Skilled nursing care provided by a qualified **nurse**. Home nursing must be supervised by an **insured member's specialist**.

Homeopathy

A type of alternative medicine that must be carried out by a member of The Faculty of Homeopathy, Society of Homeopaths or Alliance of Registered Homeopaths.

Hospital

Any hospital that is on the most recent hospital list that you're covered for.

In-patient

A patient who is admitted to **hospital** and who occupies a bed overnight or longer, for medical reasons.

Insured dependant

Your insured husband, wife or partner, who live at the same address as you

Your insured children, who must be under the age of 21 at the **cover start date**.

Insured member

Any qualifying employee or person in the **company** whom we accept for cover.

Medically underwritten/medical underwriting

The basis on which you have applied for cover and the process we use to decide the terms on which we will accept you and your **insured dependants**, based on the medical information we receive when you make your application.

Nurse

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

Osteopathy

A type of alternative medicine that must be carried out by a member of the General Osteopathic Council (GOsC).

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**.

Physiotherapy

Treatment carried out by a person who is registered with the Health Professions Council (HPC) as a physiotherapist.

Plan start date

The date on which the plan began, as shown on your certificate of insurance.

Plan year

A period of 12 months from the **plan start date** or from any **annual renewal date**.

Planholder

The **company** which has the contract with us.

Private ambulance

A road vehicle built solely for use as an ambulance and run by a registered private ambulance service.

Professional or semi professional sports

Taking part (including part time participation) in a sporting activity as a means of livelihood or for direct financial gain.

Rehabilitation

Medical services aimed at restoring a person's function and independence following eligible in-patient **treatment** of a disease, illness or injury.

Related condition

Any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury.

Specialist

A medical practitioner who is fully registered and licensed with the General Medical Council, and who is recognised by us in writing. They must either:

- hold or have held a substantive consultant post with the NHS, or hold a Certificate of Completion of Training (CCT) and be registered on the Specialists Register, or
- fulfil the qualification criteria requirements set by the Postgraduate Medical and Educational Training Board (PMETB) and be registered on the Specialists Register.

We reserve the right to withhold or remove recognition of any **specialist** for reasons such as suspension of registration, fraud or unreasonable charges.

Treatment

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

UK

Great Britain and Northern Ireland, including the Channel Islands and the Isle of Man.

Complaints procedure

Our commitment to you

We understand that sometimes things can go wrong. You are important to us, so if you have reason to complain we want to know. We will try to resolve your complaint quickly in a professional and helpful way.

How to contact us

You can contact us by letter, phone or email. It will help if you give your name, address and plan number. Either send us a secure message via our Member Zone at pruhealth.co.uk/member. Call us on the number shown on your certificate of insurance.

Or you can write to us at:

PruHealth Customer Services
Stirling, FK9 4UE

How we will deal with your complaint

The time it takes to resolve your complaint will depend on how complex it is and how much investigation we have to do. We will always try to resolve your complaint as quickly as possible, keeping you informed of our progress.

We will:

- Acknowledge your complaint promptly
- Tell you who is dealing with your complaint so contacting us is easier. This person will be a trained complaint handler not directly involved with your case before the complaint
- Fully investigate your complaint and send you a detailed report about our findings. We will clearly explain the reasons behind our decision and what action we will take to put things right, if appropriate
- Update you every four weeks if the investigation is not complete and explain the reason for the delay.

What to do if you are still not happy with the outcome

We want to resolve complaints to your satisfaction whenever possible. If we cannot reach agreement with you, you can refer your complaint to the Financial Ombudsman Service.

The Financial Ombudsman Service is an impartial adjudicator and provides a free, independent service for resolving disputes with financial services firms.

If you are going to ask the Financial Ombudsman to review your case, you should do so within six months of our giving you our final decision on your complaint. You can contact the Financial Ombudsman in the following ways:

The Financial Ombudsman Service

South Quay Plaza
183 Marsh Wall
London E14 9SR

Enquiry line: 0800 023 4567
Fax number: 020 7964 1001
Website: www.financial-ombudsman.org.uk
Email: complaint.info@financial-ombudsman.org.uk

If you contact the Financial Ombudsman Service, this does not affect your right to take legal action if you are dissatisfied with and do not accept the outcome of the review.

Other important information

Your rights under the Financial Services Compensation Scheme

As a member of a PruHealth plan, you will be protected by the Financial Services Compensation Scheme. If we are unable to pay your claim because we have become insolvent or are no longer in business, the scheme may arrange to transfer your company's plan to another insurer, or provide a new plan. If this isn't possible it will provide compensation of 90% of the claim, with no upper limit.

More details about the Financial Services Compensation Scheme can be found on their website: www.fscs.org.uk

Statement of demands and needs

This plan is designed to meet the needs of people and organisations who wish to ensure their health requirements are met quickly. We aim to offer increased choice and access to high quality facilities. Our products will also reward you if you make an effort to lead a healthy lifestyle. To ensure you are completely confident that our products will meet your needs, we would advise you to read the information we give you both before and immediately after we have completed a sale with you.

PruHealth Data Protection Notice

Why should you read this notice?

We think it is important for all our customers to be made aware of what information PruHealth Group* holds about them and to have the reassurance of knowing that we comply with the Data Protection Act.

How we use your personal information

The PruHealth Group will use your information (including information provided about your dependants) for underwriting and administration purposes. By taking out a plan with us, you agree to us processing your personal information and sensitive personal information (e.g. health information). We will also use your information for statistical data analysis, management information and fraud prevention purposes.

Who we may give personal information to

We may disclose your personal information to our business associates, agents and service providers for the purposes above. Your information may be processed by service providers in a country outside the European Economic Area, which may not have the same standard of data protection as in the **UK**. We will ensure appropriate safeguards are in place to protect your information.

We will pass your information to any legal or regulatory body if required to do so. We may also use your information or give it to others, for research, statistical purposes or to improve our services, but we will remove your name and address from this first. If you have appointed an insurance adviser we will send them copies of correspondence relating to the plan and any renewal documentation. We may disclose information about a claim to them, although no medical information will be provided without your consent.

Your information, and that of others also covered by the plan, may be disclosed to other parties (for example other insurance companies) with a view to preventing fraudulent or improper claims.

Processing claims

In the event of a claim we may have to give some information to those involved in your **treatment** or care, and/or your representative (if you have chosen one). This will be done confidentially. Correspondence about all claims (including those made by dependants) will be addressed to the **planholder** in respect of individual plans. If a dependant does not wish us to correspond with the **planholder** in relation to their claim, and if they are aged 18 or over, they should take out a separate plan in their own name. If you have another insurance plan that covers the same costs that you are claiming from us, then we may also disclose your relevant personal information to that other insurer so that we can ensure we only pay our proportion of the claim.

Group plans

If you belong to a group plan you may want to ask your employer whether an insurance adviser has been appointed, so that you know who may have access to your personal information. We may disclose information about a claim to the administrator / Group Secretary of a group plan, but no medical information will be provided without your consent. Correspondence about any claim, (including when made by a dependant of an insured employee), will be restricted to that needed to handle the claim, and will be addressed to the insured employee.

Our marketing policy

PruHealth, our group of companies and our business associates, service providers and agents may use your personal information to inform you of other services and products that may be of interest to you by telephone, post, email or text. Please call our Customer Services Department if you would prefer not to receive details of other products.

Obtaining a copy of the information we hold about you

You have the right to request a copy of the information we hold about you (for which we may charge a fee) and to have any inaccurate information corrected by writing to us at the below address. Where information has been supplied by a medical practitioner, you should be aware that we need their consent before we can supply this to you, or alternatively you can request such information direct from the practitioner.

Data Protection Co-ordinator
Prudential Health Services Limited
Marshall Point
4 Richmond Gardens
Bournemouth
BH1 1JD

Disposal of information

We will continue to hold information about your plan for a reasonable period of time after it has ended. We will then dispose of your personal information in a responsible way to maintain your confidentiality.

*PruHealth is a joint venture between Prudential in the **UK** and Discovery Holdings Limited in South Africa. The PruHealth Group includes Prudential Health Limited and Prudential Health Insurance Limited, both trading as PruHealth, and Prudential Health Services Limited trading as PruHealth and/or PruProtect.

Important regulatory information

PruHealth is the trading name of Prudential Health Limited, Prudential Health Insurance Limited and Prudential Health Services Limited. Prudential Health Limited, registration number 05051253, and Prudential Health Insurance Limited, registered number 02123483, are insurers that underwrite the insurance products. Prudential Health Services Limited, registration number 05933141, is an insurance intermediary with FSA authorisation to mediate insurance business in the **UK** (excluding Channel Islands and the Isle of Man). Prudential Health Services Limited acts as an agent of Prudential Health Limited and/or Prudential Health Insurance Limited, and arranges and provides administration on insurance plans underwritten by Prudential Health Limited and/or Prudential Health Insurance Limited. Our registered offices are at Laurence Pountney Hill, London EC4R 0HH. Prudential Health Limited, Prudential Health Insurance Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority (FSA). You can check our authorisation on the FSA's Register by visiting the FSA's website: www.fsa.gov.uk/register or by contacting the FSA directly on 0845 606 1234.

The products we offer

Prudential Health Services Limited only offers private medical insurance products underwritten by Prudential Health Limited and Prudential Health Insurance Limited. Prudential Health Services Limited can offer other insurance products from a specific range of insurers. A list of insurers and insurance products is available on request.

Appendix 1

Your guide to our moratorium clause

Please read this guide as it tells you how we deal with pre-existing medical conditions if you join under our moratorium clause.

What is the purpose of PruHealth's medical insurance plans?

Our plans provide you with benefit for the cost of treating medical conditions which arise after the date you have been accepted for cover. So, like any other type of insurance, you take out cover with us to protect yourself against the cost of unforeseeable events.

What about pre-existing medical conditions?

Like other medical insurers we have to exclude them from cover, otherwise people could join just to have **treatment** for a medical condition they already have. If we allowed people to do this, our premiums would have to be much higher.

How do you exclude pre-existing medical conditions from cover?

With our moratorium clause, we do not ask you to give details of your medical history or make you undergo a medical examination. Instead, we apply a straightforward exclusion clause (our 'moratorium clause') which says:

We don't pay claims for the **treatment** of any medical condition or **related condition** which you have received medical **treatment** for, had symptoms of, asked advice on or to the best of your knowledge and belief were aware existed in the five years before your cover started (a 'pre-existing' medical condition).

However, subject to the plan terms and conditions, a pre-existing medical condition can become eligible for cover providing you have not:

- consulted anyone (e.g. a **GP, dental practitioner**, optician or therapist, or anyone acting in such a capacity) for medical **treatment** or advice (including **check-ups**), or
- taken medication (including prescription or over-the-counter drugs, medicines, special diets or injections),

for that pre-existing medical condition or any **related condition** for two continuous years after your **cover start date**.

This clause can easily be broken down into three parts:

- Firstly, medical conditions that are covered from the first day of your insurance. These are conditions that are new to you after taking out your plan.
- Secondly, pre-existing medical conditions which become eligible for cover after at least two years continuous insurance. We cover them if you have stayed free from receiving any **treatment**, advice or medication for a continuous period of two years after taking out your plan.
- Thirdly, pre-existing medical conditions which we permanently exclude from cover. We exclude them because you will need regular or periodic **treatment**, advice or medication and you will never be able to remain free of this help for any continuous two-year period.

To help you understand how this clause works, we have set out a series of model questions and answers to the typical queries often raised:

What is a 'related condition'?

*A **related condition** is any medical condition that is considered to be an underlying cause of, or directly caused by, another medical condition. For example: high blood pressure and heart disease; recurrent sore throats and tonsillitis.*

I suffer from high blood pressure for which I have to take tablets every day. How does this affect my cover?

*Because you need continuous **treatment** for your medical condition, cover for this or any **related condition** would be permanently excluded.*

Some time after my cover has started, I go to my doctor for a routine visit and a heart condition is diagnosed. It has obviously developed during the period before the start of my plan. Would I be covered?

*The clause only applies to any medical condition or **related condition** (or both) which you were aware existed in the five years before the start of your plan. If:*

- *the heart condition was first diagnosed after you joined the plan; and*
- *you had no previous **treatment** for any obviously **related condition**, such as high blood pressure or chest pains; and*
- *you were not aware of any symptoms;*

benefit would be available even if it was proved that the condition existed before your plan began.

I have a medical condition that has existed during the five years before my cover began. I experience symptoms from time to time but I don't see my doctor about it, I just take an over the counter medicine that I buy myself. Will I be able to claim for this condition, as I have not sought medical advice or taken any prescribed medication for it?

*The moratorium excludes all conditions that you were aware of during the five years before your cover began, even if you have not needed to see a doctor about them or taken prescribed medicine. The condition will become eligible for cover, subject to the terms and conditions of your plan, if you have not received any medical advice or **treatment** or taken any medication for that condition, or any **related condition**, for a continuous period of two years after your cover starts.*

What if I suspect that I am suffering from a condition, for example, I have a lump, but have not seen a doctor for the condition or received any firm diagnosis? Would I be covered if a visit to my doctor after the start of the plan revealed that surgery for that condition was necessary?

Because you were aware of the condition during the five-year period before the start of the plan, even though you weren't quite sure what it was, it would be excluded from cover for at least the first two years of the plan.

What if I am uncertain whether **treatment** I received before the start of my plan is related to the condition for which I later wish to claim?

*Before undergoing any private **treatment** for which you wish to make a claim under your plan, you must submit a fully completed claim form to us to gain written pre-authorisation for your claim. This way we'll be able to establish the full facts about your condition and proposed course of **treatment** and will confirm our decision to you before you incur the costs of **treatment**.*

NOTE: These questions and answers provide broad guidance to the operation of the moratorium clause. Obviously, each claim is dealt with and treated on its own merits. How the clause is interpreted depends entirely on the facts presented. When we receive a fully completed claim form, we will be pleased to tell you whether cover is available before you have **treatment**.

Appendix 2

Chronic conditions information

It is important when buying private medical insurance to understand that it is designed to cover **treatment** for curable (**acute**) **conditions**. It does not usually cover long-term treatment of **chronic conditions** where the purpose of that **treatment** is primarily just to keep the symptoms under control. Unfortunately, the cost of covering **treatment** of such conditions would make private medical insurance prohibitively expensive. This information is designed to help you understand more about what we mean by **chronic conditions** and when we will and will not cover **treatment** of these.

Please note that this guide does not include reference to **cancer treatment**. This is because we provide much more detail about this in *Appendix 3*.

What is a chronic condition?

A '**chronic condition**' is a disease, illness, or injury that has at least 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.

At PruHealth we cover the cost of **treatment** for **acute conditions**. These are conditions that respond quickly to **treatment** which aims to return you to the state of health you were in before suffering the condition, or which leads to your full recovery.

However, there are certain medical conditions that can end up needing regular consultations and **treatment** over a long period of time. These are the kinds of

conditions which we, and the medical profession, usually refer to as **chronic conditions**. We will normally not cover **treatment** of a **chronic condition** if the purpose of the **treatment** is just to control the symptoms.

What does this mean in practice?

Do be reassured that when you first become ill with a **chronic condition** we will pay for any **specialist** consultations and **diagnostic tests*** you need to have in order to find out the cause of your symptoms. We will also pay for any initial **hospital treatment** you require in order to stabilise your condition.

However, there may come a point when the kind of **treatment** you are receiving appears only to be monitoring your state of health or keeping the symptoms of your condition in check rather than actively curing it. When such circumstances arise, we will discuss the situation with you. We may also ask for your consent to contact your **GP** or **specialist** to obtain further information about your condition and **treatment**. We will always take into account your own specific circumstances and we will never withdraw cover for that condition without giving you a reasonable amount of time to make alternative arrangements.

(*providing your plan covers these)

What if your condition gets worse?

Although we might have withdrawn cover for a **chronic condition**, it does not necessarily mean that cover is permanently withdrawn.

If your condition gets worse and this is not part of the normal progress of the illness or a recurring relapse, then we may cover the **treatment** necessary to return you to the state of health you were in before your condition worsened. Examples of when **treatment** would be covered are explained in the next section.

Examples of chronic conditions

The following are typical examples of **chronic conditions** and how we would usually deal with them. All of these examples assume that the chosen plan provides cover for the particular condition and **treatment**, that the plan premiums are being paid and that the first symptoms of the condition arose after the start of cover.

Example 1

Alan has been with PruHealth for many years. He develops chest pain and is referred by his **GP** to a **specialist**. He has a number of investigations and is diagnosed as suffering from angina. Alan is placed on medication to control his symptoms.

*We cover Alan's initial consultations and tests and advise him that we will cover further consultations with his **specialist** until his symptoms are well controlled.*

Two years later, Alan's chest pain recurs more severely and his **specialist** recommends that he has a heart bypass operation.

*We confirm to Alan that we will cover this operation as it will substantially relieve his symptoms and stabilise the condition. We also advise him that we will cover his post-operative **check-ups** for one year to ensure that his condition has been stabilised.*

Example 2

Eve has been with PruHealth for five years when she develops breathing difficulties. Her **GP** refers her to a **specialist** who arranges for a number of tests. These reveal that Eve has asthma. Her **specialist** puts her on medication and recommends a follow-up consultation in three months to see if her condition has improved. At that consultation Eve states that her breathing has been much better, so the specialist suggests she have **check-ups** every four months.

*We cover Eve's consultations and tests and agree to pay for her next **check-up**. However, we advise her that we will not be able to cover her regular **check-ups** after this because her condition is now well controlled.*

Eighteen months later, Eve has a bad asthma attack.

*Due to the severity of the asthma attack, Eve needs an emergency admission to an NHS hospital which our plans are not designed to cover. However, once her condition has stabilised, we agree to cover the cost of one follow-up consultation with her **specialist** to make sure that her symptoms are well-controlled again.*

Example 3

Deirdre has been with PruHealth for two years when she develops symptoms that indicate she may have diabetes. Her **GP** refers her to an endocrinology **specialist** who organises a series of investigations to confirm the diagnosis, and she then starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments to the medication regime, the **specialist** confirms that the condition is now well controlled and explains that he would like to see her every four months to review the condition.

*We pay for the **treatment** of Deirdre's condition up to this point. However, we advise her that because her condition is now stabilised we will not be able to continue to cover her regular four month **check-ups**. We tell Deirdre that we will cover one more **check-up** so that she has time to make alternative arrangements. We will not cover her medication at any time.*

One year later, Deirdre's diabetes becomes unstable and her **GP** arranges for her to go into **hospital** for **treatment**.

*Assuming the admission is on an emergency basis, then this will usually be to a NHS hospital which our plans are not designed to cover. However, once she has been discharged we will pay for one further **check-up** to make sure that her condition is now stable.*

Example 4

Bob has been with PruHealth for three years when he develops hip pain. His **GP** refers him to an osteopath who treats him every other day for two weeks and then recommends that he return once a month for additional **treatment** to prevent a recurrence of his original symptoms.

*As Bob's plan includes cover for alternative therapies, we pay for two weeks of **treatment** as this helps stabilise his symptoms. We also tell him that we cannot cover his regular monthly **treatments**, as these are designed just to keep the symptoms in check but that if his symptoms worsen he should contact us again.*

If Bob's condition did deteriorate significantly and his consultant recommended a hip replacement, PruHealth would cover the cost of this. As the operation would replace the damaged hip and thereby cure Bob's problem, we would pay for all the costs relating to this operation.

Appendix 3

Our cancer cover explained

The following table gives more information about our cover for **cancer** so that you can fully understand this important part of your plan. There are two levels of cover for **cancer**, 'Full cancer cover' and 'Core cancer cover'. The details given below are based on the 'Full cancer cover' but we show where the cover differs for 'Core cancer cover'.

You will need to check your certificate of insurance to find out which level of cover you have.

	What's covered	What's not covered
Where am I covered for treatment?	<ul style="list-style-type: none"> ■ You're covered in full for eligible treatment at any hospital or specialist cancer unit that is on your chosen hospital list ■ You're also covered in full for eligible treatment at home that would otherwise have to be delivered in hospital providing this is given by suitably qualified medical staff recognised by us ■ We pay a charitable donation of £75 for each day spent in a hospice for end stage cancer. 	<ul style="list-style-type: none"> ■ As with all other treatment, you will have to pay a contribution towards your costs if you choose to be treated at a hospital or other facility that's not on your chosen hospital list

	What's covered	What's not covered
<p>What diagnostic tests am I covered for?</p>	<ul style="list-style-type: none"> You're covered in full for diagnostic tests arranged by your specialist and for associated consultations with your specialist. You're also covered for CT, MRI and PET scans that take place in a hospital or specialist cancer unit on your chosen hospital list. <p>Important note: Where it is unclear that diagnostic tests and associated consultations are cancer-related then the cost of these will initially come out of any out-patient cover you may have. Once there is a firm diagnosis of cancer then these costs will be removed from your 'Out-patient cover' and will be set against your 'Core cover'.</p>	<p>We don't cover:</p> <ul style="list-style-type: none"> diagnostic tests arranged by anyone other than your specialist any diagnostic tests or treatment not considered clinically appropriate within the UK genetic tests that are designed to find out how susceptible you are to getting cancer normal preventive screening as with all other treatment you will have to pay a contribution towards your costs if you choose to be treated at a hospital or other facility that's not on your chosen hospital list.
<p>What types of surgery am I covered for?</p>	<ul style="list-style-type: none"> You're covered in full for surgery used for diagnostic reasons as well as surgery to remove a cancer (tumour) 	<ul style="list-style-type: none"> We don't cover surgery that is unproven (experimental), though we may make a contribution towards the costs where this is in place of established treatment. <p><i>Please also see 'Important information about your cover' paragraph 1.12 for more detail</i></p>

	What's covered	What's not covered
<p>What drug therapies am I covered for?</p>	<p>Cover for drug therapies includes the following:</p> <ul style="list-style-type: none"> ■ Full cover for chemotherapy (the use of drugs to destroy cancer cells), including anti-sickness drugs and oral chemotherapy prescribed by an oncologist ■ Full cover for hormone therapy and bisphosphonates therapy. <p>'Core cancer cover' exception: <i>Under 'Core cancer cover', hormone therapy and bisphosphonates therapy are only covered in full when combined with chemotherapy. Cover is restricted to three months if they are prescribed on their own. This limit applies for the whole of the time you are covered by us (whether under this plan or any other plan with us).</i></p> <ul style="list-style-type: none"> ■ Full cover for biological therapy (which the National Institute for Health and Clinical Excellence (NICE) defines as: 'A substance which aids the body's natural defence system in order to inhibit the growth of a tumour'), including monoclonal antibodies (MABs) and cancer growth blockers. <p>'Core cancer cover' exception: <i>Under 'Core cancer cover', cover for biological therapy is limited to 12 months from when you first start to receive this treatment. This limit applies for the whole of the time you are covered by us (whether under this plan or any other plan with us).</i></p>	<p>We don't cover:</p> <ul style="list-style-type: none"> ■ the use of drugs outside the terms of their licence ■ any drugs that would normally be prescribed by your GP ■ experimental drugs where there is no evidence of their effectiveness ■ personal expenses ■ any treatment not considered clinically appropriate within the UK.

	What's covered	What's not covered
Am I covered for preventive treatment?	<ul style="list-style-type: none"> No, you're not covered for preventive treatment – please see more about this in the next column 	<p>Our plans are primarily designed to help diagnose and treat an eligible condition where symptoms have occurred after your cover started. This means we don't cover:</p> <ul style="list-style-type: none"> normal screening such as breast screens generic tests to see if you're susceptible to a certain type of cancer treatment such as surgery to remove a breast where this is done solely to prevent the development of breast cancer because a genetic test or family history have shown a significantly greater risk of developing the disease vaccines such as the vaccine given to prevent cervical cancer
Am I covered for radiotherapy?	<ul style="list-style-type: none"> Radiotherapy is covered in full, including when given for pain relief 	
Am I covered for end of life care?	<ul style="list-style-type: none"> Yes, we cover care received solely to relieve pain and other symptoms at the end stage of cancer 	<ul style="list-style-type: none"> The cost of personal care services, home adaptation or the supply of special bedding or other equipment

	What's covered	What's not covered
What cover do I have for monitoring my condition after I've finished my treatment?	<ul style="list-style-type: none"> We will cover medically necessary follow-up tests and specialist consultations needed to monitor your condition <p><i>'Core cancer cover' exception:</i> Under 'Core cancer cover', follow-up tests and consultations are covered for a maximum period of five years from the last cancer treatment date.</p>	
What other types of treatment am I covered for?	<p>We will also cover:</p> <ul style="list-style-type: none"> stem cell therapy initial reconstructive surgery necessary following surgery to remove a tumour new drugs or other treatments where, even though they may not have been reviewed or recommended by NICE, there is adequate evidence of their effectiveness. 	<p>We don't cover:</p> <ul style="list-style-type: none"> in relation to stem cell therapy, the costs associated with finding a donor or for any other costs that do not relate solely to the stem cell therapy itself more than one reconstructive surgical operation to the same part of the body. The initial surgery must also take place within five years of the original surgery alternative/ complementary therapies (unless you have the 'Therapies cover' option on your certificate of insurance).

How our cancer cover works in practice

The following examples are designed to show how our **cancer** cover works in practice. All of these examples assume that the chosen plan provides cover for the particular condition and **treatment**, that the plan premiums are being paid and that the first symptoms of the condition arose after the start of cover:

Example 1

Beverley has been with PruHealth for five years when she is diagnosed with breast **cancer**. Following discussion with her **specialist** she decides to have the breast removed followed by breast reconstruction. Her **specialist** also recommends a course of radiotherapy and chemotherapy. In addition she is to have hormone therapy tablets for several years. Will her insurance cover this **treatment** plan and are there any limits to the cover?

*We pay for the cost of the consultations and **diagnostic tests** to establish the diagnosis. We then pay for the mastectomy and the associated reconstructive surgery, as long as this takes place within five years of any related **treatment**. We then cover the course of radiotherapy and chemotherapy in full.*

Under our 'Full cancer cover' we will pay the cost of the hormone therapy in full as well as the cost of medically-necessary follow-up consultations and monitoring.

*'**Core cancer cover**' exception: we will pay the cost of the hormone therapy in full whilst this is being prescribed at the same time as any chemotherapy. However, once chemotherapy has stopped, we will then only pay for the hormone therapy tablets for a further three months after which we would expect her **GP** to continue prescribing it if still medically necessary. Follow-up consultations and tests will be covered for up to a maximum period of five years.*

Example 2

Cara has previously had breast **cancer** which was treated by lumpectomy, radiotherapy and chemotherapy under her existing plan. She now has a recurrence in her other breast and has decided to have a mastectomy, radiotherapy and chemotherapy. Will her insurance cover this and are there any limits to the cover?

*We will cover both the eligible **treatment** of new cancers and the **treatment** of complications of cancer and/or secondary cancers. So we would pay for the cost of*

Cara's mastectomy and the course of radiotherapy and chemotherapy in full. We will also cover the cost of any associated follow-up consultations where medically necessary (but limited to five years under our 'Core cancer cover').

Example 3

Monica, who was previously treated for breast **cancer** under her existing plan, has a recurrence which has unfortunately spread to other parts of the body.

Her **specialist** has recommended the following treatment plan:

- A course of six cycles of chemotherapy aimed at destroying **cancer** cells to be given over the next six months
- Monthly infusions of a drug (bisphosphonate) to help protect the bones against pain and fracture. This infusion is to be given for as long as it is working (hopefully years)
- Weekly infusions of a drug to suppress the growth of the **cancer**. These infusions are to be given for as long as they are working (hopefully years).

Will her insurance cover this **treatment** plan and are there any limits to the cover?

*We will cover in full all aspects of Monica's **treatment**.*

*'Core cancer cover' exception: if the monthly infusions to protect her bones are being given at the same time as the chemotherapy, then we will also cover this **treatment** in full. However, once the chemotherapy **treatment** has finished, we will then pay for any further infusions for a maximum period of three months after which we would expect the NHS to continue the infusions if still medically necessary. Regarding the weekly infusions to suppress the growth of the **cancer**, these would fall under the definition of biological therapy and cover would be limited to twelve months.*

Example 4

Sharon has end stage **cancer** and would like to be admitted to a hospice for care aimed solely at relieving symptoms. Will her insurance cover this and are there any limits to the cover?

As hospices don't charge for their care we make a donation of £75 for each day spent in a hospice.

Appendix 4

Vitality The Personal Health Fund (PHF)

How the PHF works

The PHF is a pot of money for you to use to pay for certain services and **treatments** that aren't usually covered by health insurance. The amount of money available is dependent on your Vitality status. When you join PruHealth, you'll start on Bronze status when you complete your Health Review, which gives you a starting pot of £75. The pot then increases in line with improvements in your Vitality status as you go through the year. The following table shows how:

You start off on Bronze	£75
When you reach Silver	Add £50
Silver	£125
When you reach Gold	Add another £50
Gold	£175
When you reach Platinum	Add another £50
Platinum	£225

So, the maximum PHF available in the first **plan year** is £225 per adult **insured member**. In the second and subsequent **plan years**, when you complete your Health Review you start again with £75 but you can also add any of your PHF that you didn't use in your previous year. Also, to help kick-start your Vitality points in the new **plan year**, you carry over 10% of the points earned at the end of the previous year.

Here's a summary of the services you can use your PHF for (please visit our website for full details on these services and how to claim):

- a) Optical – You can use your PHF for sight test fees, fitting fees, spectacles, lenses, spectacle frames, contact lenses, spectacle repairs, prescription swimming or diving goggles and prescription sunglasses
- b) Dental (providing you don't have dental cover with us) – You can use your PHF for **check-ups** and **treatment** at a **UK** dentist. **Treatment** can include braces, fillings, crowns and bridges, plus hygienist fees

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- c) Health screens – You already get a 50% discount for our approved health screens and you can use your PHF towards the rest of the cost of a health screen with an approved partner
 - d) Private **GP** costs – You can use your PHF for consultations with a private **GP** or private walk-in centre. Cover includes minor **diagnostic tests** undertaken by the private **GP**
 - e) **Physiotherapy** – You can use your PHF to pay for **physiotherapy** without needing referral from your **GP** or **specialist**
 - f) Chronic prescription benefit – If you have a **chronic condition** that needs a regular prescription, you can use your PHF for a prescription pre-payment certificate (either 3 or 12 months certificates)
 - g) 24-hour **GP** helpline – giving you access to a doctor at any time, day or night. And although they won't be able to prescribe medicine, they can often work out what's wrong from your symptoms and can guide you on what to do next.

Important notes about the Personal Health Fund (PHF)

- You must complete our online Health Review each year before you can use your PHF;
- Each adult on the plan must complete their Health Review to unlock their portion of the PHF. For example, if only one adult on a family plan completes their Health Review, only fifty percent of the available allocation will be released. The full balance of the PHF will only be released once two adults (one of which must be the **insured member**) have completed their Health Review;
- When you use money from your PHF, the amount available for future use will be reduced accordingly. You will not need to call us for authorisation each time you want to use your PHF except where it's for a prescription pre-payment certificate. You can find out how to claim by visiting our website;
- Any unused part of your PHF will carry over into the next **plan year**, providing your scheme renews with this benefit;

- The PHF may be withdrawn from any **annual renewal date** if your scheme no longer meets the eligibility criteria for this option or if your employer chooses to withdraw it. In these circumstances any unused funds in your PHF will be lost. The same applies if your scheme is cancelled or when your own cover ends;
- You cannot take any part of your PHF as cash; it can only be used to pay for eligible benefits that are available at the time;
- Sometimes your PHF may only be sufficient to part-pay for your chosen benefit and you will have to make up any difference;
- If you add an adult dependant partway through a **plan year**, then they shall be entitled to a proportion of the PHF, at the Vitality status you've achieved at the time they join, based on the length of time left to the end of the **plan year**;
- If an adult dependant leaves the scheme partway through a **plan year** then, even though this might affect your Vitality status, any remaining funds in your own PHF will remain untouched.

Vitality linked excess

This option is only available for schemes of 10 or more insured employees and must be selected by your employer. You should check your certificate of insurance to see if you have this option. It's a great way of rewarding you for improving your Vitality status. Here's how it works:

You start off with an **excess** of £250. The **excess** may be 'per claim' or 'per person per **plan year**' and you will need to check your certificate of insurance to find out which one it is.

This **excess** then reduces as you improve your Vitality status, meaning that you could end up not having to pay any **excess** at all if you need to make a claim, as the following table shows:

Vitality status	Excess level
Bronze	£250
Silver	£100
Gold	No excess
Platinum	No excess

Important notes about Vitality linked excess

- The Vitality status we'll use to work out what **excess**, if any, is applicable when you claim is the one showing on our system when you first start your **treatment**;
- If there's a delay in recording your Vitality points for any reason and it turns out that your status was actually higher at the time of your first **treatment**, then we'll use that higher status to work out your **excess**, if any;
- It is your responsibility, and is in your best interests, to record your point scoring activities to ensure you get the maximum benefit from our Vitality programme;
- If your Vitality status reduces at an **annual renewal date** because you've not maintained the Vitality status you'd achieved in the previous **plan year**, then any claim after that renewal will be subject to the **excess** that applies for the lower Vitality status;
- The Vitality linked **excess** may be withdrawn from any **annual renewal date** if your scheme no longer meets the eligibility criteria for this option or if your employer chooses to withdraw it. If this happens, then any new **excess** agreed with your employer will apply from the relevant **annual renewal date**. In the absence of any specific instruction from your employer about their choice of **excess**, then we'll automatically apply an **excess** of £250 per person per plan year. This **excess** would be payable on the first invoice received for costs incurred in the new **plan year**. Please always refer to your latest certificate of insurance to find out what **excess** applies.

