

Your policy summary and terms and conditions of your health insurance



# Contents

---

	page
Your policy summary	3
Terms and conditions of your health insurance	7
1. Cover and benefits in detail	12
2. Underwriting	20
3. Exclusions	22
4. Policy terms and conditions, general conditions, policy administration	26
5. Complaints	35
6. Law and interpretation	36
7. Currency	37
8. Glossary of definitions	37
How to contact us	43

# Your policy summary

**This policy summary highlights the benefits of your PruHealth private health insurance.**

**Please read your policy document for full terms and conditions.**

## Here is a reminder of who PruHealth are and what we offer

- It is an insurance scheme underwritten by PruHealth that aims to cover the cost of private medical treatment for acute conditions for UK residents.
- It provides the breadth of cover you'd expect from a leading health insurer.
- You will have access to the highest standards of care and treatment as quickly as possible.
- The duration of cover is 12 months.

## What benefits does this plan offer me?

- With our Vitality programme, everyone can benefit from a healthier lifestyle. If you eat well, exercise and maintain an all round healthy lifestyle, you could get greater discounts with our Vitality partners. You could also receive a renewal reward which is based on your Vitality engagement and how much you claim. In the first year, we will work out your renewal reward using the claims that have been paid out in the first 10

months of your policy. In the years that follow we'll look at claims for a full year. The full year will be 10 months of the current policy year and 2 months of the previous policy year. Please read your Membership Certificate for full details of your renewal reward.

- You'll earn Vitality points too for certain healthy activities such as health screens and exercising at the gym. Proof of activities must be submitted within six months of the activity. Your Vitality points increase your Vitality status. The higher your status, the greater your Vitality reward partner discounts.
- Prices with our Vitality partners may increase during the year. (Please see section 1.16 of your policy document for full details).

## What will this plan cover?

- You are covered for a wide range of acute conditions. These are diseases, illness or injuries which are likely to respond to treatment with the aim of returning you to the state of health you were in before you suffered the condition.
- Complete your Health Review and you'll be given your own Personal Health Fund, or "PHF". This is an amount of money you can use to pay for certain services and treatments that aren't usually covered by health insurance. You can see the amount of money you have to spend and the list of benefits your employer has chosen for you on your membership certificate. Completion of the Health Review also unlocks your following year's renewal reward and access to the Vitality reward partners.
- Please read the '**Cover and benefits in detail**' section in your policy document for full details on what your plan covers. This includes details on our full cancer cover.

## What our plans do not cover:

As with many private medical insurance plans, there are some standard treatments and conditions that we don't cover. These include:

- Any day-to-day monitoring or treatment of most chronic conditions. Examples of chronic conditions include diabetes and asthma
- Any pre-existing conditions in the first two years of the plan, for moratorium underwritten plans
- Emergency treatment or visits to your GP
- Pregnancy and childbirth
- Self-inflicted injuries
- Cosmetic treatment
- Treatment for obesity
- Deafness
- Any other conditions explicitly excluded

Please read the 'Exclusions' section in your policy document and your summary of benefits for full details on what your plan does not cover.

Depending upon the plan your employer has chosen for you, there may be times when you are required to contribute towards the treatment you receive. This will be either an excess or co-payment, or where your provider's charge exceeds the PruHealth fee maximum. Please see your membership certificate for details of any excess or co-payments that apply.

## Out of hospital list co-payment

An out of hospital list co-payment applies for services outside of your selected hospital list. A 40% co-payment will apply to the hospital charges for an inpatient admission outside of your selected hospital list. A 40% co-payment will apply to the tariff for a diagnostic scan outside of your selected hospital list.

## How do I claim?

We hope you don't need to claim but if you do we've made the process as simple as possible.

- **Step 1: Visit your GP.** If they refer you for treatment, tell them you have cover with PruHealth and ask for the following:
  - Full details of your condition/injury, diagnosis and intended treatment
  - Full name and address of the specialist or therapist and the hospital/clinic you've been referred to.
- **Step 2: Phone us on 0800 092 7333.** Once you have all the details, call our dedicated Claims Team for your authorisation number. Make sure you have your membership number on hand when you call. Write this authorisation number down and take it with you to the specialist. If you have treatment without having the authorisation number, it could mean you may not be covered for the treatment.

You might be asked to give details of your condition over the phone, so you may want to make the call in private. Log in to the Member Zone at [pruhealth.co.uk/member](http://pruhealth.co.uk/member) and click on 'My cover' to double check details of your cover.

You may be able to receive an authorisation number online. Please log in to the Member Zone at [pruhealth.co.uk/member](http://pruhealth.co.uk/member) to find out.

- **Step 3: Book your appointment with the specialist and start your treatment.** When you go for your treatment, make sure you take the authorisation number with you. If you need further visits, ask for a procedure code and description of the treatment or investigation. Always speak to our Claims Team to make sure you're covered for further treatment.
- **Step 4: Settling the bill.** In most cases, bills will be sent directly to us. If you do get a bill, forward it to us at **PruHealth Customer Services, Stirling FK9 4UE**. If you make a payment yourself, send us the bill with proof of payment and we'll pay you back.

## What if I need to complain?

We hope that you never need to complain, but if you do, you can write to us at:

**PruHealth Customer Services,  
Stirling FK9 4UE.**

Copies of our Complaint Handling Procedures are also available at this address. Or you can call us on **0800 096 6322**.

If you are not satisfied with our reply you can take your complaint to:

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

[www.fsa.gov.uk/register](http://www.fsa.gov.uk/register) or by contacting the FSA directly on **0845 606 1234**.

This is a free service. Using it will not affect your legal rights.

## How to contact us

### Online

Via our Member Zone at [pruhealth.co.uk/member](http://pruhealth.co.uk/member) and send us a secure message.

### By post

PruHealth Customer Services  
Stirling  
FK9 4UE

### By phone

0800 092 7333

Please note that PruHealth can only give information on PruHealth products.

# Terms and conditions of your health insurance

## About this document

This document reflects the terms and conditions of the scheme as agreed between PruHealth and your employer.

Please refer to this document with your membership certificate for full details of cover and exclusions that may apply.

Words in italics in this document are defined terms which have a specific meaning. You should check their meaning in the glossary at the back of this document.

## 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's model for private medical insurance is based on a successful concept in South Africa.

## About Prudential UK and Discovery Holdings

Established in 1848, today, Prudential plc is a leading international financial services company. There are approximately 21 million customers, policyholders and unit holders and some 23,000 employees worldwide. Discovery Holdings was founded in 1992 as a specialist health insurance company in South Africa. It is now one of the market leaders in healthcare and life insurance in South Africa.

For more information visit [www.prudential.co.uk](http://www.prudential.co.uk) and [www.discovery.co.za](http://www.discovery.co.za)



Best Individual  
PMI Provider 2006,  
2007, 2008 & 2010  
Health Insurance  
Company of the Year  
2006 & 2007



Best use of e-business  
by a provider 2010



Best Individual PMI  
Provider 2006,  
2007, 2008 & 2010  
Best Group PMI  
Provider 2007



Best PMI  
Provider 2007 & 2008



Overall winner of  
the best Customer  
Experience league  
table for 2008

## **Important regulatory information**

PruHealth is the trading name of both Prudential Health Limited and Prudential Health Services Limited. Prudential Health Limited, registration number 5051253, is an insurer that underwrites the insurance products. Prudential Health Services Limited, registration number 5933141, is an insurance intermediary with FSA authorisation to mediate insurance business, and acts as an agent of Prudential Health Limited. Our registered offices are at Laurence Pountney Hill, London EC4R 0HH. Both Prudential Health 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](http://www.fsa.gov.uk/register) or by contacting the FSA directly on 0845 606 1234.

## **The products we offer**

Prudential Health Services Limited offers products underwritten by Prudential Health Limited and additional insurance products from other insurers. If you want to see this list of insurers and insurance products, it is available on request.

## **Statement of demands and needs**

This *policy* is designed to meet the demands of people and organisations who want to ensure their health needs 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. We advise that you read the information we give you both before and immediately after we have completed a sale with you. This is to ensure that you are completely confident that our products will meet your personal needs.

## **Data Protection**

PruHealth, our group of companies and our business associates, service providers and agents will use your information, together with other information, for administration, customer services, marketing and fraud prevention. We will only pass your information to them for these purposes.

We will also pass your information to any legal or regulatory body such as the Financial Ombudsman or the Financial Services Authority if we are required to do so.

We may pass certain details of your information to your employer for the purposes of administering the scheme. This may include details of your claims history but will not include any medical information.

If your employer has appointed a broker in relation to this *policy*, we may also need to pass certain information of yours to that broker.

Please rest assured that we will always maintain the greatest care in the transfer of this information to the parties noted and act in accordance with the most up-to-date data protection legislation to ensure your confidentiality is not breached in any way.

For the above purposes it will be necessary to transfer your information to countries that provide a different level of data protection from the UK. We have contracts in place to ensure your information is protected in accordance with UK law.

You have a right to obtain a copy of your personal information (for which we may charge a fee) and to have any inaccuracies corrected by writing to:

**PruHealth**  
c/o The Privacy Manager  
Information Risk and Privacy Team  
Prudential Assurance Company Ltd  
3 Sheldon Square  
London, W2 6PR.

# Your PruHealth policy terms and conditions

---

## Overview

This is the *policy* wording and benefit description for the PruHealth private medical insurance (PMI) taken out by the *policyholder*.

The *policy* is a contract of insurance with the *policyholder*, to provide cover for the employees as detailed in this *policy* document.

PruHealth expects that this *policy* will enable the *policyholder* to protect and enhance the wellbeing of their employees and of their dependants in times of illness and health.

It is intended to complement rather than replace NHS services provided in the UK.

Any examples contained in this *policy* wording are for illustrative purposes only and do not reflect the totality of the circumstances described by the relevant clause.

## Contacting us

You can contact us for more information or further clarification on the benefits, cover, exclusions and the rules included in this *policy*, as follows:

### Online

Via our Member Zone at [pruhealth.co.uk/member](https://pruhealth.co.uk/member) and send us a secure message.

### By post

PruHealth Customer Services  
Stirling FK9 4UE

### By phone

0800 092 7333

Or contact your adviser.

## How we will communicate with you

We will use a *member's* email address as the primary form of contact regarding this *policy* and our Vitality programme. Please note we generally do not send paper copies of our *policy* documentation or Vitality information to you unless specifically requested. All *policy* documentation can be found by logging in to our secure online Member Zone at [pruhealth.co.uk/member](https://pruhealth.co.uk/member).

## 1. Cover and benefits in detail

Please refer to the membership certificate for details of cover and exclusions that specifically apply to the *member*.

Subject to these documents, we will pay for the *treatments* and services as expressly laid out in the membership certificate. These are subject to the conditions of cover, definitions and exclusions detailed later in this *policy* document. We will not pay for any other *treatments* or services unless we expressly agree to do so in writing.

### Inpatient Care

- *Hospital charges*
- Specialist, consultant fees
- *Diagnostic tests*
- Radio- and chemotherapy
- *Psychiatric treatment.*

### Outpatient Care

- Specialist consultations
- Diagnostic scans
- *Diagnostic tests*
- Physiotherapy
- Chiropractic and osteopathy
- Radio- and chemotherapy
- *Psychiatric treatment.*

### Other Benefits

- Complementary and alternative therapies
- Childbirth cash benefit
- Home nursing
- Private ambulance
- Parental accommodation
- NHS hospital cash benefit

### Notes

- Fees charged by PruHealth recognised consultants includes surgeons', anaesthetists' and physicians' fees.
- Diagnostic scans include CT, MRI and PET scans. These must be following consultant referral only and also within the *member's* selected hospital list. A co-payment of 40% of the *tariff* will apply for scans undertaken outside of *member's* selected hospital list.
- Other *diagnostic tests* including pathology, X-rays and physiological tests such as an ECG.
- For physiotherapy, chiropractic and osteopathy. Cover will only apply up to the number of authorised sessions
- Payment of any of these benefits affects the *member's* renewal reward, see Section 4.12

Cover is available only to employees whose employer's Head Office is in the UK and is for *treatment* in the UK, Channel Islands and the Isle of Man.

PruHealth will cover fees charged by consultants who hold or have held an NHS post or equivalent and are registered as a specialist with the General Medical Council. Other *therapists* must be registered with appropriate regulatory bodies. We will pay in full where charges are within the *PruHealth fee maxima* for the services provided. If the proposed provider charges outside the range the *member* may be expected to pay the difference. This will be specified at the claim authorisation stage.

The selected hospital list where the *member* can be treated is specified in the membership certificate and is available on our website. PruHealth hospital lists may change from time to time. We recommend that the *member* check the most up to date version on our Member Zone before their *treatment* commences.

Our hospital lists include some of UK's leading private hospital groups. The *member's* hospital list will be able to provide most services which are available within their purchased benefits. If the *member* has any problems finding a service they need in the selected hospital list, they should contact us and we will help to locate a

facility and/or consultants who provide that service. In certain circumstances this may mean they will need to travel to get the service within the selected hospital list and avoid a co-payment.

If the *member* goes to a hospital not on their selected hospital list they will be liable to contribute up to 40% of the *hospital charges* relating to their *treatment*.

### **1.1 Benefit limits**

Any benefit limits stated apply for each person covered under the *policy*. These limits also apply to the total of claims over the *policy* year. Where a *combined limit* applies it means that the cost of any *treatment* paid for out of those benefits accumulates towards the overall limit. There may be sub-limits within the overall *combined limit* and the *member* should check their membership certificate for further details.

### **1.2 Excesses**

*Excesses* apply per person covered under the *policy*. *Excesses* relate to the total amount of claims over a *policy year* for an individual, not to each claim event. Please note that after every renewal a new *excess* will apply to each person covered. A rolling *excess* is when the *excess* is only payable once every 12 months. The membership certificate will detail which type of *excess* you have.

### 1.3 Out of hospital list co-payment

An *out of hospital list co-payment* applies for services outside of a *member's* selected hospital list. A 40% co-payment will apply to the *hospital charges* for an *inpatient admission* outside of the *member's* selected hospital list. A 40% co-payment will apply to the *tariff* for a diagnostic scan outside of the *member's* selected hospital list.

### 1.4 PruHealth fee maximum

If the proposed specialist fee is above the *PruHealth fee maximum* for that *treatment*, the member will have to contribute the difference between this amount and the claimed amount. Alternatively, the *member* can choose to have *treatment* with a different practitioner who charges within the *PruHealth fee maximum* for that *treatment*.

### 1.5 Intensive and high dependency care

#### Critical care

We will pay for *critical care* where it is part of the expected post-operative management of the *member* and where the intention is to treat a disease, illness or injury which is likely to respond quickly to *treatment*.

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. We do not pay for any level of *critical care* which is not medically necessary for the condition being treated.

### 1.6 Psychiatric care

PruHealth will actively manage psychiatric *treatment* in order to achieve the best outcome for the *member* on a case by case basis. 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 (see Exclusions: *chronic conditions*).

The overall psychiatric limit applies for both *inpatient* and *outpatient treatment* or services and includes both accommodation and *treatment* costs. The *outpatient* sub-limit is for *outpatient treatment* and accumulates to the overall psychiatric limit.

### 1.7 Rehabilitation

Cover is available for rehabilitation, which is *treatment* intended to restore health or mobility or return the *member* to independent living, following a stroke or injury. The rehabilitation must be integral to eligible *inpatient treatment*,

should start no more than two months after initial diagnosis or date of injury, will normally be covered for 30 days only and will be managed within our guidelines for *chronic conditions*. A specialist should make the referral to a rehabilitation unit for the *treatment* to be eligible.

### 1.8 Complementary and alternative therapies

Where covered, this category includes healthcare systems and practices that are not presently considered to be part of conventional medicine. To be eligible for cover, these therapies 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, 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 the Provider Zone. *Treatment for pre-existing conditions, chronic conditions* and associated medicines and products is not covered.

### 1.9 Childbirth cash benefit

This is payable on the birth of a *child* to a *member* who has been covered by a *policy* for at least nine months prior to the birth. In order to claim the benefit the *member* must provide PruHealth with a copy of the birth certificate and request the payment of benefit within six months of the birth.

### 1.10 Nursing at home

In order to claim the nursing at home benefit, such *treatment* must:

- immediately follow a period of *inpatient treatment* for a medical condition covered by the *policy*
- be for *treatment* that would otherwise be provided in hospital as an *inpatient*
- be undertaken by a trained *nurse*; and
- be recommended and carried out under the supervision of the *member's* specialist.

### 1.11 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.

### 1.12 Parental accommodation benefit

This benefit is paid to enable one parent to stay in the same hospital as their *child* (up to and including 12 year olds) when the *child* is admitted as an *inpatient* 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 the *child* covered under the *policy* goes to an NHS hospital for *treatment*, the *child* is eligible for the NHS hospital cash benefit as described in the clause below.

### 1.13 NHS hospital cash benefit

This benefit applies only to NHS day cases or stays in a *general NHS ward*, not an NHS PPU. The NHS hospital cash benefit is paid out only for conditions that PruHealth would have covered if treated privately under the *policy*. This benefit wouldn't be available for a visit to Accident and Emergency (A&E) as A&E *treatments* are not covered by PruHealth. Any standard or personal exclusions still apply (refer to Section 3).

If the *member* is admitted to an NHS hospital for an acute event and is eligible for transfer to a private hospital, they will be eligible for the cash benefit if they choose not to move to a private facility.

If the *member* does choose to claim the cash benefit, this will be recorded as a claim in the normal way and will affect the calculation of the reward payable to the *member* on renewal (see Section 4.12). The *member*, or their representative, must call PruHealth to request authorisation for the claim in accordance with normal procedure (see Section 4.10b). They must submit the NHS discharge form to PruHealth as evidence of their *treatment* or hospital stay.

### 1.14 Cancer benefit

PruHealth will pay for *treatment* for all stages of *cancer*, for both cure and *palliative* care, subject to our general terms and conditions. Consultant surgeon, oncologist and radiotherapist fees will be subject to our *fee maxima* for the service provided. Radiotherapy and chemotherapy are fully covered on all plans, subject to authorisation. The membership certificate shows whether there are any limits on the plan. Where an annual *outpatient* benefit limit applies, consultations and *diagnostic tests* directly related to *cancer treatment* will be fully funded.

*Treatments* that follow all available National Institute for Health and Clinical Excellence (NICE) guidance will be covered in full. NICE is responsible for providing national guidance on promoting good health, preventing and treating ill health. We will evaluate therapy not yet considered by NICE on a case by case basis using all currently available evidence from properly controlled mature phase III clinical trials and may pay for the use of a new, licensed anticancer drug, or new use for a drug with a licensed indication where there is credible scientific evidence to support its use.

Appropriate bone marrow or stem cell transplants are also covered.

No time limits are placed on *treatment* and follow up care for *cancer* provided cover is continuous and while you are eligible for benefits. Rules covering *chronic conditions* do not apply to *cancer*.

A donation is available for hospice care.

PruHealth will not pay for complementary and alternative therapies as the primary *treatment for cancer* as part of the *cancer* benefit. However, we will pay for complementary and alternative therapies from the Complementary and Alternative Therapies benefit (see section 1.8).

### **1.15 The Personal Health Fund (PHF)**

The PHF assists *members* in funding certain day-to-day health expenses which would not typically be covered by *PMI* benefits and are not included as standard on their *policy*. *Members* must complete a "Health Review" on the Member Zone during each *policy* year in order for PHF benefits to be available. Claims will only be paid if the PHF has been activated by completing the Health Review.

The PHF has limits as agreed with the employer. The PHF covers expenses, up to the agreed limits from the list of benefits as chosen by the employer. This will be shown on the membership certificate.

It covers expenses, up to the annual allocation or limit set, from the following list of benefits:

#### **a) Health screens**

We will pay for health screens and chargeable fitness assessments with our Vitality screening partners only. We will pay the discounted Vitality rate for the screen or fitness assessment.

#### **b) Consultations for chronic conditions**

We will pay for ongoing consultations for *chronic conditions*, radiology and pathology from the PHF. Usually ongoing management of a *chronic condition* is excluded from cover. We will cover acute flare-ups from the main benefit; however we will also cover check-ups for *chronic conditions* from the PHF, subject to underwriting. The *member* will need to register their *chronic condition* and treating doctor with us. You can do this by calling our Customer Services Team on 0800 092 7333.

#### **c) Maternity related expenses**

This benefit will help a *member* to pay for her pre-natal care, such as scans, midwife or specialist consultations. The delivery itself and any post-natal care will not be covered.

#### **d) Access to eligible benefits without GP referral**

This benefit is for when *members* need to see a specialist or practitioner, but have not been referred by a GP. The benefit will only be paid for *outpatient* benefits which are currently covered on the plan.

#### **e) Private GP cover**

When this option is selected by the *policyholder*, we will cover claims for private general practitioners and walk-in centres. Cover includes consultations, *diagnostic tests* and certain procedures performed by a *member's* GP.

When a *member* uses funds from the PHF the amount available for future use will be reduced accordingly. To use funds from the PHF, a *member* will not need to call PruHealth for authorisation each time they need to see their practitioner. Usage of the PHF will not affect their Vitality rewards, their *excess* or their claims amount. In some cases the PHF will not be sufficient to pay for the *treatment* in full, but may pay in part. Where appropriate, PruHealth will use the PHF to pay for claims if they cannot be paid from the main benefits as detailed in Section 1.

### **PHF exclusions**

PruHealth will not pay funds from the PHF if the *member's* doctor or therapist is not appropriately registered, or if the *treatment* needed is associated with an underwriting exclusion or general scheme exclusion. We will also not pay funds used from the PHF if they are for *treatment* unrelated to one of the benefits associated with the PHF as chosen by the employer.

### **PHF renewal**

If the *member* does not exhaust their PHF by the end of the *policy year*, the unused amount (calculated as the limit less claims made from the PHF in the year) will roll over and be available to them for the following year, in addition to the new scheme year's allocation. The PHF may also be increased by an annual allocation at *policy renewal* (see Section 4.12).

The Health Review will need to be completed annually to make the funds available.

### **Joiners and leavers**

The PHF is the amount of additional benefit the *member* is entitled to under this *policy*. It is not redeemable for cash to the *member* or to the employer at any point in time and it will cease without value when the contract is terminated by the employer or when the *member's* cover ceases.

Where the contract is not renewed by the employer and a payment is due from the PHF for *treatment* made when the *policy* was active, PruHealth will pay this from the PHF if it has sufficient funds to cover all or part of the *treatment*. If the member has joined the company part way through their *policy year* they will not be eligible for the full year's allocation to the PHF. The allocation will be prorated based on remaining time until *policy renewal*.

### **1.16 Vitality**

This is our dynamic programme in which *members* can engage in a wide selection of health-promoting activities and be awarded points. These points move them through different statuses, each of which has a published threshold based on the number of adults on the *policy*. While higher statuses entitle *members* to higher value rewards, all *members* have the opportunity to participate in an evolving

range of offers. The programme promotes *members'* health and reduces the likelihood of their need to make a claim on the *policy*.

### **i) Vitality Status**

There are four statuses, Bronze, Silver, Gold and Platinum. A *member's* Vitality status is determined by the recorded efforts that the *member* makes with Vitality during a *policy year*. On renewal of the *policy*, a *member* maintains their Vitality status based on the points earned during the year until the next *policy* renewal or until the member improves it. Proof of activities must be submitted within six months of the activity. We will not be able to award points for activities if proof of such activities is not submitted within six months after the activity has occurred.

Every *member* starts at Bronze level when the *policy* commences.

Vitality status can go down following renewal if the number of Vitality points needed to maintain the status is not achieved.

Vitality status can change midway through the *policy year* as new adult dependants are added or removed.

### **ii) Vitality Commitment**

The Vitality programme evolves to give our *members* the advantage of new opportunities and technologies as they arise. It grows from our relationship with third party providers and depends on the

range of services they offer. We actively revise the ways in which points can be earned and rewarded.

Specifically, we may change the methodology for awarding points or eligible activities in the Vitality programme and the Vitality status the *member* 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.

The revisions 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 revisions may be needed to prevent the fraudulent use of benefits or as a result of other factors beyond our control.

Vitality benefits are calculated in one of two ways: as a fixed price, or as a percentage discount by reference to the standard retail rate.

We reserve the right to increase the cost of fixed price Vitality benefits during the *policy 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. Such price increases, if made, will only occur once during a *policy year* and take effect either on 1 January or 1 July. No such 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 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 the Platinum *member* would pay is £13.

The cost of Vitality benefits calculated as a percentage discount to a retailer's standard price may vary during the year if that retailer changes its standard price. For example, the discount on a Boots health screen is 50%. The current standard price is £40, so the cost to *members* is currently £20. If Boots were to reduce the standard price to £30, the cost to *members* would be £15. If the standard price was increased to £50, the cost to *members* would be £25.

Any changes to the Vitality programme, including the prices of fixed price Vitality benefits, will be communicated to you at least 42 days before the changes take effect, unless this is made impossible by factors outside our control. If the *policyholder* is unsatisfied with the changes they may cancel the *policy* in accordance with the

cancellation provisions in section 4.8 below. *Members* will still be subject to the notice period of any relevant Vitality partner, and to any applicable terms and conditions relevant to that Vitality partner.

For the avoidance of doubt, please note that this clause refers to changes to the Vitality programme made within the *policy year* and does not prevent PruHealth from applying changes and price increases at renewal following the expiry of a *policy year*.

## 2. Underwriting

### 2.1 Full Medical Underwriting

Under "full medical underwriting" a *member* will have made a declaration regarding their medical history. *Pre-existing conditions* will be identified from that declaration and exclusions applied to the *policy*. The *member* can request that these exclusions are reviewed at renewal. These may be removed at the underwriters' discretion.

PruHealth may request further information when a claim is being made to establish any relationship to a *pre-existing condition* and/or to check that all conditions were disclosed on the medical declaration. It is the responsibility of the *member* to disclose any *pre-existing conditions* to PruHealth upon joining the *policy*. Failure to do so may result in personal exclusions being applied and claims being declined, any

sums already paid out on the *member's* behalf being recovered by PruHealth or even cancellation of the *policy*. If the *member* has any doubts about such disclosure they should call our Customer Services Team on 0800 092 7333.

PruHealth may request further information when a claim is being made to establish any relationship to the overall exclusions in Section 3.

Complications or increased treatment costs as a result of an excluded *pre-existing* condition will not be covered.

## 2.2 Moratorium Underwriting

Under "moratorium underwriting", conditions which existed up to five years before the date of the start of cover will not be explicitly identified but may be excluded from cover for two years from the date of commencement.

We will exclude cover for *treatment* for any medical condition or related condition which the member or their covered dependants

- Have had symptoms of, whether diagnosed or not,
- Been aware of or sought advice on
- Received medical *treatment* for in the five years before the start of cover.

PruHealth will in most cases request further information when a claim is being made to establish whether the

condition is pre-existing and thereby excluded by the moratorium clause.

PruHealth may also request further information when a claim is being made to establish any relationship to the overall exclusions in Section 3.

Complications or increased *treatment* costs as a result of an excluded *pre-existing* condition will not be covered.

## 2.3 Switch/CPME Underwriting

Only *pre-existing conditions* excluded by the previous provider's *policy* will be excluded from cover, where this option is selected. PruHealth may request further information when a claim is being made to establish any relationship to a *pre-existing condition* and/or to check eligibility of the transfer against the declaration signed.

New *members* without previous medical insurance may be fully underwritten.

PruHealth may also request further information when a claim is being made to establish any relationship to the overall exclusions in Section 3.

Complications or increased *treatment* costs as a result of an excluded *pre-existing* condition will not be covered.

## 2.4 Medical History Disregarded

Where 'medical history disregarded' is selected, *pre-existing conditions* are covered subject to the overall exclusions in Section 3.

PruHealth may request further information when a claim is being made to establish any relationship to the overall exclusions in Section 3.

New *members* must join the *policy* at their earliest opportunity or at renewal. If the *member* joins more than 30 days after their earliest opportunity or renewal date, PruHealth will classify this as a material change in risk and reserves the right to underwrite the new member and their dependants. Please read section 4.5 for additional changes of risk.

Complications or increased *treatment* costs as a result of an excluded *pre-existing condition* will not be covered.

### 3. Exclusions

The following conditions and health care services are not covered by PruHealth under this *policy*. In addition, any consultations, complications or subsequent *treatment* related to these exclusions are also not covered. Please read Section 1.15 in relation to the Personal Health Fund which may assist you with paying for some of these exclusions.

#### 3.1 Accident and Emergency care

This includes all immediate care until stabilisation has been achieved.

#### 3.2 Chronic conditions

Any day-to-day monitoring and therapy of *chronic conditions* is excluded

from cover. This includes consultations by any healthcare professionals, medication, investigations (blood tests, radiology) etc. Examples of *chronic conditions* include diabetes and asthma.

However, *acute conditions* related to *chronic conditions* will be covered subject to the *member's policy* unless a specific exclusion relating to that condition has been applied. Consultations leading up to the diagnosis of a *chronic condition* will be covered. Many chronic illnesses are of a relapsing and remitting nature, requiring management of recurrent episodes where symptoms deteriorate e.g. multiple sclerosis, Crohn's disease, long-term depressive illness, psoriasis etc. The relapses are part of the normal illness course and therefore cannot be classed as acute complications of the disease and are not covered.

#### 3.3 Complications of any treatment not approved by PruHealth

This relates to unproven or unregistered *treatment* or *treatment* received whilst overseas. This also refers to increased *treatment* costs incurred for a disease, illness or injury which is ineligible for cover or for which cover has been excluded.

#### 3.4 Cosmetic treatment

Any *treatment* primarily for cosmetic reasons or resulting from previous

cosmetic *treatment* is excluded, even if the request is psychologically motivated. Breast reduction or augmentation operations are excluded, whether or not for back pain. *Treatment* which involves the removal of healthy tissue or the removal of surplus or fat tissue is also excluded.

### **Exceptions to this exclusion:**

Post-traumatic or post-surgical reconstruction to restore function or appearance is included if performed within 12 months of major injury or primary surgery. We will pay for the initial reconstructive surgery to restore function and appearance following *cancer treatment*. Any subsequent related *treatment* will only be covered if it is intended to cure an acute medical condition.

### **3.5 Deafness**

We will not cover any *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 medical condition diagnosed within the past 12 months.

### **3.6 Dentistry**

We will not cover any general conservative dental procedures, e.g. simple extractions, restorations, root canal *treatment*, implants, crowns, veneers, bridges and dentures including

periodontal or orthodontic *treatment*. Minor enamel, dentine and incisal edge fractures restored through conservative means are also not covered.

Surgical procedures performed by a consultant oral or maxillofacial surgeon will be assessed for eligibility when treating an acute medical condition for example:

- re-implantation of your own teeth following trauma;
- elective reduction of facial and mandibular fractures following recent trauma;
- surgical removal of impacted teeth, buried teeth and complicated buried roots;
- surgical drainage of a fascial space (tracking) abscess;
- removal of cysts of the jaw; and
- apicectomy.

### **We do not cover:**

- orthognathic surgery for functional (eating and speech) or aesthetic reasons; or
- procedures to prepare for orthodontics or prosthetic surgery.

### **3.7 Fertility and hormone-related treatment**

Assisted reproductive therapy and other *treatments* related to infertility and sterilisation are excluded. *Treatment*

of physiological or natural changes as a result of ageing e.g. menopause or puberty and hormone replacement therapy is also excluded.

### 3.8 Frail care

This refers to, for example, care received in convalescence and nursing homes, respite care, and domestic support that does not require a trained practitioner.

### 3.9 Gender re-assignment operations or any related medical or surgical treatment

### 3.10 General practitioner consultations or visits

### 3.11 Healthcare services related to:

- Alcohol, drug or solvent abuse
- Wilfully self-inflicted illness or injury; including *treatment* related to attempted suicide
- Injuries sustained during *participation in professional or semi-professional sports*
- Injuries sustained in a road traffic accident where a seat belt has not been worn
- Injuries sustained during participation in a wilful violation of the law
- Injuries sustained during war, terrorist activity, riot, civil commotion, rebellion or insurrection

- Any exclusion. This includes any consultations and other services related to these exclusions.

### 3.12 Medication and dressings

Medication and dressings that are administered for use during hospital *admissions* are covered.

*Outpatient* dressings or medications and any related *treatment* are not covered, nor are dressings or medications provided or prescribed to take home from hospital.

### 3.13 Experimental, unproven or unregistered treatment or practices

We will not cover experimental, unproven or unregistered *treatment* or practices that are not considered to be established UK medical practice 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). Experimental *treatment* may be considered for cover if it is conducted in a properly controlled clinical trial.

If you decide to undergo *treatment* that we consider experimental and 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 *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 terms and conditions of this *policy*
- 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*.

### 3.14 Organ transplants

### 3.15 Overseas treatment

All *treatment* provided outside the UK is excluded.

### 3.16 Pregnancy and childbirth

*Treatment* directly or indirectly arising from or required as a result of pregnancy, childbirth or infertility is not covered except for *ectopic pregnancy, hydatidiform mole, post partum haemorrhage, miscarriage, retained placenta* or *stillbirth*.

### 3.17 Preventative treatment (and regular checks)

This includes sight tests, regular monitoring of, for example, cholesterol levels, and screening for early detection

of diseases such as diabetes, *cancer* etc. The removal of healthy tissue for prevention of disease is excluded as is genetic testing of any type are not covered.

### 3.18 Refractive eye surgery and optometry

This is surgical *treatment* to correct long or short sightedness, astigmatism, or any other refractive error, including accommodating lenses following cataract surgery.

### 3.19 Retention of disposable and durable medical devices and equipment

The cost of medical devices and equipment is not covered. Examples of exclusions are bandages and dressings, unless part of *inpatient* and *day case treatment*, wheelchairs, crutches, glasses and contact lenses, external prostheses, orthotics and hearing aids. Consultations related to these are not covered.

### 3.20 Routine check-ups

Visits to a doctor where there is no specific medical complaint are excluded from cover e.g. visits to get prescriptions, blood pressure checks etc.

### 3.21 Treatment for obesity

We do not pay for *treatment* for obesity, including surgery for obesity.

### 3.22 Treatment related to suspected or previously diagnosed developmental problems, learning difficulties, or delayed speech disorders

For example, dyslexia, Attention Deficit Hyperactivity Disorder (ADHD), etc. This exclusion also includes any *diagnostic tests*. Refer to the glossary definition of *treatment*.

## 4. Policy terms and conditions, general conditions, policy administration

### 4.1 Compliance with policy terms

PruHealth's liability under this *policy* will be conditional upon the *policyholder* and each insured *member* complying with its terms and conditions and not having misled PruHealth by misstatement or concealment, either knowingly or unknowingly.

### 4.2 Policy duration

The *policy* will run for one year from the date of commencement up until the renewal date and is therefore a one year contract (this is defined as the "*policy year*"). The *policyholder* is liable to pay all premiums up until the end of the *policy year*. *Members* may enter or leave cover during this *policy year* as they enter or leave employment.

### 4.3 Cooling off

Cooling off provisions for any gym membership or other PruHealth Vitality partners depends on the terms and conditions of the relevant Vitality partner.

## During the policy year

### 4.4 Amounts due to PruHealth

This includes, but is not limited to health insurance and Vitality benefit premiums and *policy excesses* owed by the *policyholder* or *member*. Premiums include any Insurance Premium Tax (IPT) that is payable on the cover provided, as well as other taxes, levies or charges that may be introduced which are payable by law.

Premiums must be settled on or before the due date. Failure to settle within 30 days will result in a temporary hold being placed on the *policy* with the authorisation and payment of all claims being suspended. PruHealth reserves the right to pass any outstanding amounts to a debt collection agency. Any additional costs from the debt collection agency will be charged to the *policyholder*.

PruHealth reserves the right to cancel the *policy* after 30 days of payment not being received. The premiums payable by the *policyholder* will be reflected on the Employer Bill Statement, which will include all premiums up until the end of the *policy year*.

#### 4.4.1 Annual Payers

If annual payment is selected, premiums will be billed in advance for the year. Membership additions during the *policy year* will be billed at the discretion of the insurer.

A reconciliation will be done on the *policy* and issued in the tenth month of the *policy year*. Settlement is required on or before the due date. Failure to settle by the due date will result in a temporary hold being placed on the *policy* with the authorisation and payment of all claims being suspended.

#### 4.5 Change of risk

Standard premium rate changes will take effect at the end of each *policy year*. PruHealth reserves the right to apply plan and premium changes during the *policy year*, in addition to any underwriting exclusions that may have been applied to the new joiners, when the following have occurred:

- Addition or removal of a dependant or partner;
- More than 10% change in lives or policies, in any one *policy year*;
- An MHD *member* or dependant who joins more than 30 days after their earliest opportunity or renewal;
- A significant and material change in the demographic and risk profile of the group. Factors which will be considered include age, pensioner ratio, underwriting, geographical region ;
- Scheme size reduction to a maximum of one *member*;
- Correction of an error that produces a change in the premium billed e.g. correction in date of birth; and

- Any other material changes in the information or membership given as part of the application for cover under this *policy*. (Note, this excludes underwriting information.)

To make changes on policies, a *member* should contact their employer representative who can advise them on whether a change is allowed.

The employer representative can then email [administration@pruhealth.co.uk](mailto:administration@pruhealth.co.uk) or visit the Employer Zone to execute an amendment to the *policy*.

#### 4.6 Membership additions, withdrawals or other changes

If changes are made to the *policy* with an effective date prior to the requested date the *policyholder* will be liable for the outstanding amount from the effective date which will be included in the subsequent bill.

New *members* can be added to the *policy* throughout the *policy year*, subject to the underwriting rules for new joiners. The underwriting rules under which new members and their dependants are added are determined by the *policyholder*. PruHealth will allow a maximum of eight *children* to be added to any *policy*.

Newborn babies can be added to a *policy* regardless of health status if PruHealth is notified within three months of the birth. If we are notified after three months from the date of birth

then the baby will be underwritten on the same terms as the principal *member*.

New *members* will be entitled to the full amount of eligible benefit regardless of the time of year they joined. New adult dependants or partners will alter the Vitality status thresholds.

The *policyholder* is required to notify us 30 days in advance of any change in the number and identity of the *members* to be removed from the *policy*. We will send the *policyholder* a statement with each bill detailing the *members* covered in respect of each month.

If the *policyholder* fails to notify us 30 days in advance, and wishes a *member* to be removed from the *policy* retrospectively, we will make the retrospective adjustment up to 30 days prior to the date we received the notice, provided that:

- (1) the *member* has not made any claims or requested authorisation for cover within the last 30 days, and
- (2) the *member* does not make a claim within 7 days after we received notice from the *policyholder* that the *member* is to be removed from the *policy*.

If the *member* has made or makes a claim as detailed above, no retrospective adjustments will be made, and the *policyholder* will be liable to pay the premium for the member until 30 days has expired commencing from the date

we received notice from the *policyholder* to remove the member from the *policy*.

It is the responsibility of the *policyholder* to inform the *member* of their joining and leaving dates of the *policy*. PruHealth will not be responsible for covering any *treatments* that take place outside of the period of cover. Any *member* who has left the *policy* before the end of the *policy year* will not be entitled to any pro rata share of benefits they may have earned during that *policy year* in respect of low claims or Vitality status. All of a *member's* Vitality benefits will cease when their cover ceases subject to the notice period of the relevant Vitality partner. All Vitality points earned by that *member* will be removed from the *policy* and thresholds will be adjusted accordingly.

A *member* who has left the *policy* has the option to apply for a continuation of PruHealth cover with us. In order to be eligible for continuation terms, they must contact PruHealth within 30 days of leaving the *policy*. Should they be accepted on continuation terms, the direct *policy* start date will be set to the day after cover on the *policy* which was terminated.

A *member* who continues with their own individual *policy* won't necessarily have the same cover as they had on their previous *policy*. We may offer a transfer to a direct *policy* with no further underwriting, dependent on the *member's* state of health, age and

claims made. If this isn't offered, the member will be required to undergo the underwriting process again, from the date of transfer, in order to determine their new underwriting.

#### 4.7 Changes during the year

There will be no change in premium during the *policy year* unless prompted by a change covered in section 4.5 or 4.6 above or a change in applicable taxes. Subject to the above, PruHealth may vary the other terms and conditions of the *policy* during the *policy year*. PruHealth will notify the *policyholder* in writing identifying any variations in the terms and conditions at least 28 days before the variations take effect. If the *policyholder* does not wish to accept the variations, the *member* can cancel the *policy* within the 28 days without any further liability to PruHealth.

*Members* may still be subject to the notice period of any relevant Vitality partner. Please note that alterations to terms and conditions relating to Vitality partners, or charges due from *members* to access a particular Vitality benefit, do not form part of the *policy* terms and conditions and so do not fall under the scope of this term.

#### 4.8 Cancellation

PruHealth reserves the following rights:

a) PruHealth may cancel the *policy* promptly on non-payment of premium, and recover any unpaid premiums due until the end of the

*policy year* according to section 4.2 above. However, PruHealth can, at its discretion, reinstate the cover if the premium is paid within 30 days of the cancellation date.

- b) If any premium from the *policyholder* remains unpaid, PruHealth will defer payment of any claims until the premiums outstanding have been paid in full.
- c) *Members* may be withdrawn from the scheme during the *policy year*, but the total withdrawal of the scheme will only be allowed at *policy* renewal. Should the *policyholder* insist on withdrawal they will be liable for the fees for the remainder of the current *policy year*. Any authorisation or claims made for *treatment* after the date of withdrawal will not be covered by PruHealth.
- d) If the *policyholder* asks its bank to indemnify itself in respect of any premiums paid, without PruHealth's approval, PruHealth reserves the right to recover these sums from the *policyholder*.
- e) If the *policyholder* instructs its bank to cancel the debit order instruction with PruHealth, PruHealth reserves the right to recover any sums due from the *policyholder*.
- f) PruHealth may cancel this *policy* or terminate a *member's* cover or subject the cover to different terms (with retrospective effect where appropriate) if the *policyholder* or a *member* has at any time:

- Misled PruHealth by misstatement or concealment, whether or not done knowingly;
- Agreed to, assisted or concealed any attempt by a third party to defraud PruHealth; or
- Otherwise failed to observe the terms and conditions of this *policy* or failed to act with good faith in their dealings with PruHealth.

#### 4.9 Reinstatements

In the event of a *member* being withdrawn from a *policy*, the *member* will have 30 days to request a reinstatement from the effective withdrawal date. After 30 days a full declaration of health is required for consideration. Reinstatement will be at PruHealth's discretion.

#### 4.10 Claims

The procedure for *members* to follow in making a claim is laid out in section 4.10b. This section does not apply to PHF benefits which are described in Section 1.15.

##### a) Referral

The *member* will need to be referred by a general practitioner (GP) for a specialist consultation or other *outpatient treatment*, except for diagnostic scans where they need to be referred by a specialist, for that *treatment* or consultation to be covered. They will

need to be referred by a specialist for *admission* to hospital in order for *treatment* at that hospital to be covered.

##### b) Authorisation

The *member* must call PruHealth (on 0800 092 7333) or go online for authorisation before any *treatment*, including consultations, *outpatient*, day patient or *inpatient treatment* to check:

- That the intended *treatment* date falls within the *member's* period of cover
- That the *member* is eligible for cover for the *treatment* (diagnosis and *treatment* detail will be clinically assessed)
- Whether any *pre-existing conditions* or other exclusions apply. PruHealth may request medical information from a GP or specialist to confirm the history and status of the condition as part of the authorisation process
- That the specialist or therapist is recognised by PruHealth or that the conditions specified are satisfied
- That the specialist's fees are covered by the *member's* plan. If the specialist's fees are higher than *PruHealth's fee maxima*, the *member* will be responsible for the difference
- That the costs of the facility to which the *member* is to be admitted, e.g. a hospital or day clinic, are fully covered.

All authorisation requests are reviewed against PruHealth's evidence-based clinical protocols. These are derived from internationally recognised guidelines from organisations such as NICE (National Institute for Health and Clinical Excellence), the Cochrane Library, SIGN (Scottish Intercollegiate Guidelines Network) etc. Each case is reviewed on its merits and, where necessary, additional clinical information is obtained from the treating practitioner. It is important to note that PruHealth never advises the member on treatment options. We will, however, inform the member whether such treatment will be covered by their plan, based on the chosen benefits and clinical protocols.

- The *member* should have to hand:
  - the details of their condition and intended *treatment*;
  - their GP contact details;
  - the details of the relevant specialist/therapist i.e. full name, phone number and postcode; and
  - for hospital *admissions*, the *member* will be given an authorisation number and target length of stay, which the hospital will require.

All invoices must be received within six months of the *treatment* date to qualify for payment. The *member* will be liable for invoices received after six months from date of *treatment*.

Where the *member* doesn't obtain authorisation from PruHealth before getting treated, they may be liable to pay all or part of the costs of the *treatment*.

We are not always able to confirm at the time of authorisation whether or not total benefit limits have been exceeded. It is therefore possible that other claims submitted by a *member* will have caused their benefit limits to be exceeded. In such circumstances, any *treatment* costs over and above the benefit limits will not be covered.

### c) Third party claims

The *member* must, without delay, give PruHealth written notification of any claim or right of action against any third party in respect of any circumstances which gave rise to the claim under this *policy*, for example, if a *member* claims for *treatment* following a car accident where the third party may have been at fault. If the *member* decides to pursue a third party for damages, the *member* must continue to keep PruHealth fully informed in writing and take all steps

PruHealth reasonably requires in making a claim against the third party, which may include recovery of PruHealth's outlay.

If the *member* fails to inform PruHealth of a third party claim, and makes a recovery (which includes any settlement made) without including PruHealth's outlay, PruHealth reserves the right to

recover its outlay and any sums due from the *member*. PruHealth will be entitled to initiate proceedings in a *member's* name for recovery of its outlay or any sums due under this *policy*. PruHealth will have full discretion in the conduct of any such proceedings and in the settlement of any such claim.

#### d) Prevention of fraud

If any claim under this *policy* is in any respect fraudulent or unfounded, all benefit paid or due in respect of that claim will be forfeited and recoverable. Failure to disclose material information could result in the *policy* being cancelled. PruHealth also reserves the right to take appropriate legal action and/or refer the matter to the police to seek criminal prosecution. Information relating to such matters may be disclosed to others with a view to preventing fraudulent or improper claims.

### 4.11 Renewal

#### a) Plan, premium changes

- Except for the changes listed in Section 4.5 and 4.6, plan and premium changes will take effect only at the end of the *policy* year. Plan changes may be subject to underwriting requirement.
- PruHealth reserves the right to decline a plan upgrade based on the claims experience of the *policyholder* or a *member* in respect of the risk of the *policy*.

- In the event of the scheme size reducing to a maximum of one active *member*, PruHealth reserves the right to convert the *policy* from an SME to an Individual *policy* at renewal.
- PruHealth will automatically renew the *policy* unless there has been fraudulent activity or the *policyholder* or *policy* dependants have misled PruHealth in any way. Where a plan is discontinued, PruHealth will move the *member* to the closest available alternative.

### 4.12 Policy renewal

At the end of the *policy* year PruHealth may elect to offer to the *policyholder* renewal of the *policy*, possibly on altered terms to those in force, for example with different cover offered or premiums charged based on age, medical inflation and claims experience.

PruHealth will send out a renewal notice detailing the terms of renewal at least one month before the end of the *policy* year. In the unlikely event that the *policyholder* does not receive these terms at least one month before the end of the *policy* year they should notify Customer Services or their adviser.

Acceptance by the *policyholder* of the renewal terms made available in this

way to the *policyholders* and *members* will be assumed unless PruHealth is informed otherwise in writing by the *policyholder*.

The following will be taken into account for pricing at renewal:

- Age and medical inflation increase
- PruHealth's risk rating factor

The risk rating factor could be a discount or loading reflecting the assessment of risk and will change each year to reflect the risk profile of the scheme. If the maximum increase cap of 25% is applied in two consecutive years then the maximum increase cap will be removed in the third year and a higher increase will be given. The maximum loading cap will not apply for the first year if you have received a first year premium discount.

All *members* included in the *policy* at renewal, who have completed the online Health Review, will be eligible for a renewal reward which is calculated according to the table that can be found on your membership certificate. The reward payable will depend on family status, total claims paid up to calculation of the renewal terms (excluding any PHF usage) and Vitality status achieved based on the number of Vitality points earned at the date of calculation of renewal terms (see section 1.16 for information on Vitality).

The employer may select an employee renewal reward to be offered in one of two ways:

1. Cash back: a tax free cash lump sum paid via bank transfer into the *member's* nominated bank account.
2. As an increase to the *member's* PHF: Each *member's* usage allowance is increased by a factor, and then added to their PHF. This factor will be specified to the *member* prior to renewal.

The amount of the reward will be pro-rated in the following circumstances:

- If a single *policy* becomes a family *policy* or a family *policy* becomes a single *policy* part way through the *policy year*; or
- If an employee joins the company part way through a *policy year*.

Pro-rating will be based on months remaining on the *policy*, and where a part month is applicable that month will be pro-rated to the day.

## Employer cash back reward

This is payable to the employer after renewal and is based on the loss ratio and Vitality engagement of the scheme as set out below.

	Loss ratio (the ratio of total claims paid out plus adjustment divided by the total earned premiums)	Vitality engagement (% principal members above bronze at renewal)
High	90% or greater	50-100%
Medium	50 – 89%	25-49%
Low	<50%	0-24%

At renewal in 2010 an employer chose to receive cash back annually or once every three years at a higher percentage of the premium paid. The employer certificate will have more details on the reward that has been selected.

If the 3 yearly payout option has been chosen, this payout will apply for the next three years.

A minimum scheme size of ten employees is required on the renewal date, for employers to be eligible for the reward. The payment will be in the form of a cash amount and will not be offset against any premiums paid or payable. The reward will be paid six months after renewal once all claims for the preceding year have been submitted.

Annual payout- percentage of the previous years' premium paid	Vitality engagement		
Loss ratio	High	Medium	Low
High	0%	0%	0%
Medium	6%	4%	2%
Low	10%	6%	3%

3 yearly payout- percentage of the previous 3 years' total premiums paid	Vitality engagement		
Loss ratio	High	Medium	Low
High	0%	0%	0%
Medium	12%	8%	4%
Low	20%	12%	6%

### 4.13 Other insurance

If there is any other insurance covering any of the same benefits insured under this *policy*, the *policyholder* or the *member* must disclose this to PruHealth. PruHealth shall not be liable to pay or contribute more than PruHealth's proportionate share between the insuring parties.

### 4.14 Liability for treatment

Our liability under this *policy* is limited to the liability to pay for *treatment* or services in respect of claims qualifying for cover under this *policy*, in accordance with the 'Conditions of cover' and the 'Exclusions' set out above. The choice of provider of the

*treatment* or services ("provider") is the responsibility of the *member* claiming under this *policy*. We make no representations or recommendations to any *member* regarding the availability and standard of any *treatment* or services offered or provided to the *member* by any provider.

We will not be held liable to any *policyholder* or *member* 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 *policy* represents the whole and only agreement between the *policyholder* and PruHealth relating to the provision of *PMI* cover. *Treatment* authorised while the *policy* is active and which takes place after termination of the *policy* will not be covered.

Any advice, conversations, e-mails, leaflets, letters or similar communications received by the *policyholder* or any *member* in relation to the cover do not form part of this *policy*. This is without prejudice to our rights in respect of declarations made by the *policyholder* or *member* in their completed application form for this *policy*.

PruHealth makes use of Vitality partners to offer services and activities relating to the Vitality programme. While these companies are carefully selected, PruHealth cannot be held liable for any loss or harm resulting to the *member* 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.

## 5. Complaints

### 5.1 Making a complaint

We hope you never needs to complain, but if you do, they can write to us at:

PruHealth Customer Services  
Stirling FK9 4UE

If we cannot settle your complaint you may be entitled to refer it to the Financial Ombudsman Service.

### 5.2 Our complaints process

We want to deal with concerns fairly, effectively and promptly. However, some complaints are more complex than others and may take some time to investigate. We will keep the *member* informed of the progress made to resolve the complaint.

If we have not resolved a *member's* complaint within eight weeks of receiving it we will send the *member* a letter explaining why the complaint has not been resolved and confirming when we will contact them again. We will also send the *member* details of their right to refer the complaint to the Financial Ombudsman Service, if eligible to do this.

Our complaints process is available on request, by contacting us on:  
**0800 096 6322.**

### 5.3 Escalation of complaints

If a *member* is not satisfied with PruHealth's response they may then be eligible to take their complaint to the Financial Ombudsman Service by contacting them at:

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

Telephone:  
0845 080 1800

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

Website:  
www.financial-ombudsman.org.uk

The same channel of complaint may be open to the *policyholder*, subject to the rules of the Financial Ombudsman Service.

### 5.4 Compensation

The *policyholder* or a *member* may have a right to compensation if PruHealth or another authority decides that the *policyholder* has bought a plan in which the information provided by PruHealth was incorrect or misleading and resulted in financial loss.

Please contact PruHealth's Customer Services office for more information.

If PruHealth is unable to meet its financial obligations in full the *policyholder* or the *members* may be entitled to help from the Financial

Services Compensation Scheme. The limit applicable for an eligible claimant is 90% of the value of the claim.

Further information is available by contacting them at:

Financial Services Compensation Scheme  
7th floor, Lloyds Chambers  
Portsoken Street  
London E1 8BN

Telephone:  
020 7892 7300 or 0800 678 1100

Email:  
enquiries@fscs.org.uk

Website:  
www.fscs.org.uk

## 6. Law and interpretation

**6.1** This *policy* will be governed by and construed in accordance with the laws of England and Wales and will be subject to the exclusive jurisdiction of the English Courts.

**6.2** The schedule and paragraph headings are for convenience only and do not form part of the *policy* itself nor do they affect its construction.

**6.3** A person who is not party to this contract has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce any terms of this *policy*. In addition to the *policyholder*, *members* covered by the *policy* are considered to be parties to this *policy*.

## 7. Currency

Every payment to PruHealth or by PruHealth under this *policy* shall be payable in the lawful currency of the *UK*.

## 8. Glossary of definitions

Words and phrases printed in italics in this *policy* document have the meanings set out below. The following are standard definitions of common *PMI* terms and some specific to PruHealth:

### 8.1 Acute condition

A disease, illness or injury that is likely to respond quickly to *treatment* which aims to return the *member* to the state of health they were in immediately before suffering the disease, illness or injury, or which leads to their full recovery. We would consider that an *acute condition* would resolve within three months or less.

*Treatment* of an *acute condition* should be intended to deal with the underlying condition rather than provide temporary relief of symptoms.

### 8.2 Admission

The interval between the time a *member* enters a hospital ward as a day case or for an overnight stay until the time they are discharged. This does not include an *admission* to an Accident and Emergency department/ward nor an *outpatient* attendance.

### 8.3 Cancer

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

### 8.4 Children

- a) The term "*children*" incorporates biological and adopted *children* as well as *children* under guardianship. The main criterion is that they are financially dependent on the principal *member* taking out the *policy*.
- b) *Children* can remain on the *policy* past the age of 21 years, being charged as an adult and will only be removed on notification from the *policyholder* or broker.

### 8.5 Chronic condition

A disease, illness or injury, which has at least one of the following characteristics:

- a) Continues indefinitely and has no known cure;
- b) It comes back or is likely to come back;
- c) It is permanent;
- d) Means the *member* needs to be rehabilitated or specially trained to cope with it; or
- e) Needs long-term monitoring, consultations, check-ups, examinations or tests.

As we expect an acute condition to resolve completely within three months, we would begin to consider any condition lasting longer than this as chronic.

### **8.6 Combined limits**

Claims for specialist consultations, *diagnostic tests*, chiropractors, osteopaths and physiotherapists all aggregate to one limit, for each *member* of the family.

### **8.7 Complementary therapy**

Complementary disciplines are those which usually, if not invariably, complement conventional medical *treatment*, whilst alternative disciplines are those which purport to offer diagnostic and therapeutic alternatives to conventional medicine.

### **8.8 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 is considered to be *critical care*.

### **8.9 Day case treatment**

*Treatment* which means the *member* has to be admitted to hospital or a *day case* unit because they need a period of clinically supervised recovery but does not have to stay overnight.

### **8.10 Diagnostic tests**

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

### **8.11 Ectopic pregnancy**

An abnormal pregnancy where the fertilised egg attaches itself outside the cavity of the uterus.

### **8.12 Eligible treatment**

*Treatment* of an *acute condition* together with the products and equipment used as part of the *treatment* that:

- is consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the *UK*;
- is clinically appropriate in terms of type, frequency, extent duration and the facility or location where the services are provided; and
- is demonstrated through scientific evidence to be effective in improving health outcomes.

### **8.13 Excess**

The amount of money a *member* must contribute towards any *treatment* they have in a *policy year*.

### **8.14 Family membership**

A *family membership* covers two adult *members* or more.

### **8.15 General NHS ward**

This is a ward within an NHS hospital where there is generally no charge for the bed.

### **8.16 Hospital charges**

The portion of total fees paid by PruHealth for a *member's treatment* (whether *inpatient* or *outpatient*) that relates to costs incurred by the hospital. This includes, but is not limited to, accommodation, meals, drugs and surgical dressings, nursing care, operating theatre costs, eligible intensive and high dependency care, physiotherapy and any prosthesis used during an operation.

### **8.17 Hydatidiform mole**

A tumour in the placenta that occurs in early pregnancy.

### **8.18 Inpatient**

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

### **8.19 Member**

Refers to the individual *member* of the scheme included by the employer. It may also refer to their partner and any dependant *members* who are covered on the scheme by the employer.

### **8.20 Miscarriage**

Loss of a pregnancy under 24 weeks' gestation.

### **8.21 Nurse**

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

### **8.22 Out of hospital list co-payment**

Where *treatment* is received outside of the chosen hospital list, a percentage co-payment may apply to the *hospital charges*.

### **8.23 Outpatient**

A patient who attends a hospital, consulting room, or *outpatient* clinic and is not admitted as a day patient or an *inpatient*.

### **8.24 Palliative care**

Holistic therapy aimed to relieve or reduce the symptoms of those with advanced *cancer* but not to produce a cure.

### **8.25 Participation in 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.

### **8.26 PMI**

Refers to private medical insurance.

### **8.27 Policy**

The PruHealth contract of insurance to provide *PMI* cover for *members*, as detailed in this document.

### **8.28 Policy year**

The *policy* will run for one year from the date of commencement up until the renewal date and is therefore a one year contract. This is known as a *policy year*.

### **8.29 Policyholder**

Refers to the company or employer taking out this *policy*.

### **8.30 Post partum haemorrhage**

Loss of over 500ml of blood from the genital tract within 24 hours of delivery.

### **8.31 PPU**

Private patients unit. These can be separate wings or wards within an NHS hospital.

### **8.32 Pre-existing condition**

Either a diagnosed condition or an undiagnosed symptom or collection of symptoms that the *member* is experiencing or has experienced or been treated for within the last 5 years. Ongoing follow-up consultations or advice sought for conditions are classed as *treatment*.

### **8.33 PruHealth fee maximum**

The *PruHealth fee maximum* defines the upper limit of the range of fees expected by PruHealth for any *treatment* provided by a healthcare provider.

### **8.34 Related medical condition**

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

### **8.35 Retained placenta**

Part or all of the placenta (afterbirth) remains in the womb during the third stage of labour.

### **8.36 Single membership**

A *single membership* covers one adult *member*.

### **8.37 Stillbirth**

Delivery of a child which has not shown any signs of life after the 24th week of pregnancy.

### **8.38 Tariff**

The charges negotiated by PruHealth with the healthcare provider in relation to their healthcare services provided.

### **8.39 Therapists**

These include physiotherapists, chiropractors, osteopaths, acupuncturists, homeopaths, podiatrists and other practitioners as may be agreed by PruHealth.

### **8.40 Treatment**

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

### **8.41 UK**

United Kingdom (excluding the Channel Islands and Isle of Man).

### **8.42 We, us, our**

Refers to PruHealth.





# How to contact us

---

PruHealth Customer Services  
Stirling FK9 4UE

0800 092 7333

[pruhealth.co.uk](http://pruhealth.co.uk)

SME POLICY SUMMARY AND POLICY DOCUMENT PRUHM19528/11/2010



PruHealth is a trading name of Prudential Health Limited and Prudential Health Services Limited which are registered in England and Wales. Registered office at Laurence Pountney Hill, London EC4R 0HH. Registered numbers 5051253 and 5933141 respectively. Prudential Health Limited and Prudential Health Services Limited are authorised and regulated by the Financial Services Authority.