

Terms and conditions of your health insurance.

POLICY SUMMARY AND
POLICY DOCUMENT



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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.

What is PruHealth private health insurance?

- It is an insurance plan underwritten by PruHealth that aims to cover the cost of private medical treatment for acute conditions for UK residents. You must be aged 18 or over to have a PruHealth policy.
- Your policy with us is for a 12 month period.

What benefits does this plan offer me?

- With our Vitality programme everyone can benefit from a healthy lifestyle. If you eat well, take a bit of exercise and maintain an all round healthy lifestyle you could receive a reward when you renew.
- At policy renewal, PruHealth will allocate a no claims discount per policy based on claims made during the policy year. The full twelve months of the policy year will be reviewed. Where late claims are received and not taken into account these will be added into the following renewal calculation. Claims

made by any member(s) on the policy will be taken into account.

- The no claims discount will be increased by 5% for each year the member does not claim to a maximum of 35%. It will decrease by 10% if a claim is made in the policy year.
- A Vitality renewal reward will also be calculated based on a member's attained Vitality status in the policy year. The Vitality renewal reward will be based on a combination of the member's Vitality status and the monthly premium paid in the policy period.
- Prices with our Vitality partners may increase during the year. For our fixed price Vitality benefits no price shall exceed the amount equal to the change in the Consumer Price Index (since our last price increase) against the Bronze price. For our percentage discount Vitality benefits, the amount may vary during the year if that retailer changes its standard price (please see section 1.16ii of your policy document for full details).

What does each plan cover?

We have four different types of cover. You'll be able to check which one you chose by reading your membership certificate.

The Comprehensive plan covers:

- All eligible hospital fees, including specialist fees, plus greater levels of outpatient care and higher cover limits
- All eligible outpatient costs
- A wider range of additional benefits such as complementary and alternative therapies.

The Select plan covers:

- All eligible hospital fees, including specialist fees, plus greater levels of outpatient care
- Option of £0 or £250 excess.

The Core plan covers:

- All eligible hospital fees, including specialist fees
- Limited outpatient costs following and directly related to a hospital stay
- Option of £0 or £250 excess.

The Value plan covers:

- All eligible hospital fees and limited outpatient costs. The member will need to contribute a pre-set amount per benefit in the form of a fixed co-payment.

Please read the 'Summary of PruHealth plans and benefits' 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 health insurance plans, there are some standard treatments and conditions that we don't cover.

These are as follows:

- Any regular monitoring or treatment of chronic conditions. Examples of chronic conditions include diabetes, HIV/AIDS and allergies
- Any treatment received outside the UK
- Emergency treatment or visits to your GP
- Preventative treatment (and regular checks)
- Pregnancy and childbirth
- Self-inflicted injuries
- Cosmetic treatment
- Organ transplants
- Medication and dressings (except when administered during hospital admissions)
- Fertility, infertility and menopause-related treatment
- Experimental, unproven or unregistered treatment or practices
- Treatment related to developmental problems, learning difficulties, or delayed speech disorders
- Dentistry
- Refractive eye surgery and optometry
- Treatment for obesity
- Deafness

If you selected 'moratorium underwriting', any conditions that you have been affected by in the five years before the start of your cover will not be covered in the first two years of your policy. Please read the 'Underwriting' section in your policy document for full details.

Depending on the plan you have selected there may be times when you are required to contribute towards the treatment you receive through an excess or co-payment, or where your treatment cost exceeds the PruHealth fee maximum. Please see your membership certificate for details of any excess or co-payments that may apply.

Out of hospital list co-payment

An out of hospital list co-payment applies for services outside of a member's selected hospital list. For an inpatient admission outside of the member's selected hospital list a 40% co-payment will apply to the hospital charges. For a diagnostic scan outside of the member's selected hospital list a 40% co-payment will apply to the hospital tariff. Under the Value plan there will be no cover for the outpatient diagnostic scans outside of the member's 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 you need medical treatment, the first thing to do is to 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 and the hospital/clinic you've been referred to.

■ **Step 2: Give us a call on 0800 092 7333.**

Once you've got all the details, call our dedicated Claims Team for your authorisation number – jot this down and keep it safe for your trip to the specialist. If you have treatment without it, it could mean you won't be covered.

It's worth remembering that you might be asked to give details of your condition over the phone, so you may want to make the call in private. To double check any of the details of your cover, log on the Member Zone at pruhealth.co.uk/member and click on 'My cover'.

You may be able to receive an authorisation number online. Please log onto the Member Zone at pruhealth.co.uk/member to find out.

■ **Step 3: Book your appointment.**

You can now book your appointment with the specialist and start your treatment. When you go, make sure you take the authorisation number we gave 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 direct to us. If you do get a bill, simply forward it on 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.

Can I change my mind?

You have 30 days from the start date of your cover, or from when you received your policy documentation, whichever is later, to cancel your policy and receive a full refund. If you have any claims larger than your premium we will collect the difference and any outstanding claims will be cancelled. You will not receive a refund for any Vitality activities used or points earned. Cool off provisions for any gym membership will depend on the terms and conditions of the relevant gym.

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 or by contacting the FSA directly on **0845 606 1234.**

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

Compensation

You may have a right to compensation if we or another authority decide that you've bought a plan in which the information provided by PruHealth was incorrect or misleading and resulted in financial loss. Please contact our Customer Services office for more information.

If PruHealth is unable to meet its financial obligations in full you may be entitled to help from the Financial Services Compensation Scheme. Further information is available from the Financial Services Compensation Scheme. Telephone **020 7892 7300** or visit the website at www.fscs.org.uk

How to contact us

Online

Via our Member Zone at 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.

Your policy document.

About this document

This document reflects the Terms and Conditions of the *policy* as agreed between PruHealth and the *policyholder*.

Please refer to this document in conjunction 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 with some 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 and www.discovery.co.za



Winner
Best Individual
PMI Provider 2006, 2007
& 2008

Health Insurance
Company of the Year
2006 & 2007



Best Individual PMI
Provider 2006,
2007 & 2008

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. 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 or by contacting the FSA directly on **0845 606 1234**.

The products we offer

Prudential Health Services Limited only offers products underwritten by Prudential Health Limited. Prudential Health Services Limited can offer other insurance products from a specific range of insurers. If you wish 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 who wish 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. To ensure you are completely confident that our products will meet your personal demands and needs, we would advise that you read the information we give you both before and immediately after we have completed a sale with you.

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 profiling your purchasing preferences 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.

If you have 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 health insurance (*PMI*) taken out by the *policyholder*.

PruHealth expects that this *policy* will enable the *member* to protect and enhance their wellbeing and that of their dependant *members* in times of both 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 covered by the relevant clause.

Contacting us

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

Online

Via our Member Zone at **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 explicitly requested. All *policy* documentation can be found by logging in to our secure online Member Zone at **pruhealth.co.uk/member**.

Summary of PruHealth plans and benefits

'Covered' in the summary of benefits means we will pay in full where charges are within the *PruHealth fee maxima* for the services provided.

	Comprehensive	Select	Core	Value
INPATIENT CARE				
<i>Hospital charges</i>	Covered	Covered	Covered	Covered ³
Specialist consultant fees	Covered	Covered	Covered	Covered ³
<i>Diagnostic tests</i>	Covered	Covered	Covered	Covered ³
Radio- and chemotherapy	Covered	Covered	Covered	Covered
Psychiatric treatment	Combined psychiatric limit of £20,000 per policy year	Combined psychiatric limit of £7000 per policy year	None	None
OUTPATIENT CARE				
Specialist consultations	Covered	Combined limit of £750 per policy year ¹	Combined limit of £600 per policy year ^{1,2}	Combined limit of £600 per policy year ^{1,4}
Diagnostic scans: MRI, CT, and PET scans	Covered at a provider from your selected hospital list	Covered at a provider from your selected hospital list	Covered at a provider from your selected hospital list	Covered at a provider from your selected hospital list ⁴
<i>Diagnostic tests: other</i>	Covered	Combined limit of £750 per policy year ¹	Combined limit of £600 per policy year ¹	Combined limit of £600 per policy year ^{1,5}
Physiotherapy	Covered	Combined limit of £750 per policy year ¹	Combined limit of £600 per policy year ^{1,2}	Combined limit of £600 per policy year ^{1,5}
Chiropractic and osteopathy	Limit of £800 per policy year	Combined limit of £750 per policy year ¹	Combined limit of £600 per policy year ^{1,2}	Combined limit of £600 per policy year ^{1,5}
Radio- and chemotherapy	Covered	Covered	Covered	Covered
Psychiatric treatment	Combined psychiatric limit of £20,000 per policy year	Sub limit of £750 to an overall combined psychiatric limit of £7000 per policy year	None	None

	Comprehensive	Select	Core	Value
OTHER BENEFITS				
Complementary and alternative therapies	Limit of £600 per <i>policy year</i>	None	None	None
Childbirth cash benefit	£100 per child	£100 per child	£100 per child	£100 per child
Home nursing	Covered	£3,000 limit per <i>policy year</i>	£3,000 limit per <i>policy year</i>	£3,000 limit per <i>policy year</i>
Private ambulance	Covered	£60 per trip	£60 per trip	£60 per trip
Parental accommodation	Yes (for <i>children</i> of 12 or under, 1 parent)	Yes (for <i>children</i> of 12 or under, 1 parent)	Yes (for <i>children</i> of 12 or under, 1 parent)	Yes (for <i>children</i> of 12 or under, 1 parent)
NHS hospital cash benefit	£100 per day (overall annual limit of £2000)	£50 per day (overall annual limit of £2000)	£50 per day (overall annual limit of £2000)	£50 per day (overall annual limit of £2000)
EXCESS				
	Option of £0, £100, £250, £500 or £1000	Option of £0 or £250	Option of £0 or £250	No excess available
VITALITY BENEFITS				
	Full Vitality benefits	Full Vitality benefits	Full Vitality benefits	Full Vitality benefits

- 1 The combined limit means that claims for specialist consultations, *diagnostic tests*, physiotherapy, chiropractic and osteopathy all aggregate to one limit for each *member* on the *policy*.
- 2 Cover is restricted to *treatment* following and directly related to an eligible hospital *admission*. We consider *treatment* which falls within a maximum of six months of the eligible hospital *admission* to be directly related to the original *admission*. Generally any *treatment* after six months would not be considered to be directly related to the original hospital *admission*.
- 3 A co-payment of £100 applies per *inpatient admission* within selected hospital list.
- 4 A co-payment of £50 applies per *interaction*.
- 5 A co-payment of £20 applies per *interaction*.

Notes:

- Specialist/consultant fees: includes surgeons', anaesthetists' and physicians' fees whilst as an *inpatient* or day case patient
- 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* include pathology, X-rays and physiological tests such as an ECG.
- Physiotherapy, chiropractic and osteopathy. Cover will only apply up to the number of authorised sessions.

1. Cover and benefits in detail

We will only pay for the *treatments* and services as expressly laid out in the schedule on page 12, subject to the conditions of cover, definitions and exclusions detailed later in this *policy* document and laid out in the membership certificate. We will not pay for any other *treatments* or services unless we expressly agree to do so in writing. Please read the summary of benefits in conjunction with 'Conditions of cover' and 'Exclusions' set out over the page. Cover is available only to permanent residents of 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. If the proposed provider charges outside the *PruHealth fee maximum* the *member* may be expected to pay the difference. This will be specified at the claim authorisation stage.

1.0 Hospital lists and co-payments

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 and we recommend that the *member* check the most up-to-date version on our Member Zone before their *treatment* commences.

Our hospital lists are made up of some of *UK*'s leading private hospital groups. The *member's* selected 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 obtain 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 the summary of benefits in this document for further detail.

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.

1.3 Value plan co-payments

A co-payment is a set value a *member* must contribute towards *treatment* specified in the summary on page 12, for services provided within the *member's* chosen hospital list. Co-payments apply per *member* per claim event covered under the *policy* and applies each time they see or receive *treatment* from their medical provider. The co-payment amount will vary for different *treatment* types.

The co-payment will be deducted from the *PruHealth fee maximum* or the *tariff* that we will pay in relation to the *treatment* in question.

1.4 Out of hospital list co-payment

An out of hospital list co-payment applies for services outside of a *member's* selected hospital list. For an *inpatient admission* outside of the *member's* selected hospital list a 40% co-payment will apply to the *hospital charges*. For a diagnostic scan outside of the *member's* selected hospital list a 40% co-payment will apply to the *hospital tariff*. Under the value plan there will be no cover for the *outpatient* diagnostic scans outside of the *member's* selected hospital list.

1.5 PruHealth fee maximum

If the proposed *treatment* cost 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*.

1.6 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.

1.7 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 *treatment* 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* or services and accumulates to the overall psychiatric limit.

1.8 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 2 months after initial diagnosis or date of injury and will normally be covered for 30 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.

1.9 Complementary and alternative therapies

Where covered, this category includes medical and 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 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 the Member Zone. *Treatment for pre-existing conditions or chronic conditions* is not covered, nor are associated medicines and products.

1.10 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.

1.11 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 by and carried out under the supervision of the *member's* specialist.

1.12 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.

1.13 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.

1.14 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*.

Consequently, this benefit wouldn't be available for a visit to Accident and Emergency (A&E) as A&E *treatment* is 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 chose 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 4.10b). The *member*, or their representative, must call PruHealth to request authorisation for the claim in accordance with the normal procedure (see Section 4.9b) and submit to PruHealth the NHS discharge form as evidence of their *treatment* or hospital stay.

1.15 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. Radiotherapy and chemotherapy are fully covered on all plans, subject to authorisation. There are no financial limits on *inpatient* and *outpatient cancer treatment* on any plan and a donation is available for hospice care. Where an annual *outpatient* benefit limit applies, consultations and *diagnostic tests* directly related to *cancer treatment* will be fully funded.

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 anti-*cancer* drug, or new use for a drug with a licensed indication where there is credible scientific evidence to support

its use. Chemotherapy, radiotherapy and surgery for the *treatment* of *cancer* will be covered provided it follows guidance issued by the National Institute for Health and Clinical Excellence (NICE).

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 therapy as part of the Complementary and Alternative Therapies benefit. (See section 1.9).

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 which 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 4 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.

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

Vitality status can go down following renewal if the number of Vitality points required 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 also be required to prevent the fraudulent use of benefits. Revisions may be required 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 the condition was disclosed on the medical declaration. It is the responsibility of the *member* to disclose any *pre-existing conditions* to PruHealth upon joining the *policy* and failure to do so may result in personal exclusions

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

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 or 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.

2.3 Switch/CPME Underwriting

Where this option is selected, only *pre-existing conditions* excluded by the previous provider's *policy* will be excluded from cover. 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.

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

3. Exclusions

The following conditions and healthcare 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.

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 complications 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 e.g. multiple sclerosis. The relapses are part of the normal illness course and therefore cannot be classed as acute complications of the disease.

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.

3.6 Dentistry

This includes any general conservative dental procedures, e.g. simple extractions, restorations, root canal *treatment*, implants, crowns, veneers, bridges and dentures including periodontal or orthodontic *treatment* are excluded. 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 the *member's* 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 Experimental, unproven or unregistered treatment or practices

This includes those that are not considered to be established *UK* medical practice or for which there is insufficient evidence of safety or effectiveness e.g. not having 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.

3.8 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.

3.9 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.

3.10 Gender re-assignment operations or any related medical or surgical treatment

3.11 General practitioner consultations or visits

3.12 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.

3.13 Medication and dressings

Except when administered for use during *hospital admissions*, medicines or *outpatient* dressings provided or prescribed to take home are not covered.

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.

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 developmental problems, learning difficulties, or delayed speech disorders

For example, dyslexia, Attention Deficit Hyperactivity Disorder (ADHD), etc.

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 start date of cover until the renewal date and is therefore a one year contract (this is defined as the "*policy year*").

4.3 Cooling off

The *member* has 30 days in which to change their mind.

They should notify PruHealth within those 30 days that they do not want their cover to continue. The 30 days starts from the later of the following:

- a) the start date of the cover of the *policy*; or
- b) receipt of the *policy* documentation

Please contact PruHealth customer services on **0800 434 6510**.

During this period, a full refund of any premiums paid less any claims is available. Any *excess* of claims made over premiums paid will be recoverable by PruHealth from the *policyholder* and any outstanding claims will be cancelled. There will be no refund in respect of any Vitality activities or points earned under a cancelled *policy*.

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

Settlement is required within 30 days of the date payment is due in order for cover to be maintained. 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 cancel the *policy* after 30 days of payment not being received. PruHealth reserves the right to use a debt collection agency for the collection of any unpaid amounts.

If the *member* cancels the *policy* under the terms of section 4.8 of this *policy* document, they should be aware that premiums are billed in arrears and they may therefore be liable for further premiums.

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* when the following have occurred:

- addition or removal of a dependant or partner;
- correction of an error that produces a change in the premium billed e.g. correction in date of birth; or
- 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).

4.6 Membership additions, withdrawals or other changes

Dependants or partners can be added to the *policy* throughout the *policy year* on the same underwriting terms as the *policyholder*. If they cannot satisfy the eligibility for that underwriting type they will be asked to select another underwriting option. PruHealth will allow a maximum of 8 *children* to be added to the *policy*.

Should changes be 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 dependants or partners will be entitled to the full amounts of benefit limits regardless of the time of year they joined. They can then participate in Vitality activities and earn Vitality points up to the renewal of the *policy*. New adult dependants or partners will alter the Vitality status thresholds.

Dependants or partners can be withdrawn from the *policy* throughout the *policy year*. PruHealth must be notified no less than 30 days in advance of the termination.

Any *member* who leaves 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 the *member* will be removed from the *policy* and thresholds will be adjusted accordingly.

To make changes to your *policy* contact Customer Service Team on **0800 092 7333**.

4.7 Changes during the year

There will be no change in premiums during the *policy year* unless prompted by a change covered in section 4.5 or 4.6 above.

Subject to the above, PruHealth may vary the other terms and conditions of the *policy* during the *policy year*. PruHealth shall 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

a) Rights to cancel

- (i) The *policyholder* is free to cancel the *policy* during the term by giving notice in accordance with the terms of this section.
- (ii) PruHealth may only cancel the *policy* during the term if the *policyholder* fails, as detailed in this section, to meet their obligations.

b) How to cancel

- (i) The *policy* may be cancelled with effect from the end of any *policy* month (the "Cancellation Point"). For example, if you joined PruHealth on the 15th of any month, your *policy* month will end on the 14th of the following month and the months thereafter. Please note that the 15th of the month is only an example and you will need to check the date you joined PruHealth to calculate the end of your *policy* month.
- (ii) To cancel, the *policyholder* must contact PruHealth Customer Services on 0800 434 6510. This must be before their chosen Cancellation Point. Therefore, if they joined PruHealth on 15th January, they would need to call PruHealth no later than the 14th

of any month in order for the cancellation to be effective at the end their *policy* month. If they fail to cancel by the end of their *policy* month (for example if they called on 15th of that month), they would be liable to pay a further monthly premium and the *policy* would be effective until the 14th of the following month.

- (iii) The *policyholder* shall remain liable for any premium payments due in respect of all cover in the periods prior to the Cancellation Point.
- (iv) The *policyholder* will remain liable for all payments due under the *policy* until they instruct PruHealth directly (either by telephone or by writing) to cancel in accordance with this section, or until PruHealth itself cancels the *policy* as outlined below.

- (v) The *policyholder* cannot cancel the *policy* by instructing their bank to cancel any applicable direct debit, or by otherwise failing to pay any sum due, or by failing to observe any of the terms and conditions of this *policy*.
- c) Effect of cancellation
- (i) The *policy* will end on the Cancellation Date. For the avoidance of doubt, the membership of all *members* will end with the *policy*, including the membership of the *policyholder's* dependants.
 - (ii) PruHealth shall not make any payment for *treatment* which is provided after the Cancellation Point, irrespective of whether it has been previously authorised. Nevertheless, prior to the Cancellation Date claims may continue to be authorised and *treatment* provided and paid for, regardless of whether the *policyholder* has already given notice to cancel the *policy*.
- d) When PruHealth may cancel
- (i) PruHealth reserves the right to cancel the *policy* if the *policyholder* fails to pay any due sum on its payment date. Except as provided in paragraph 4.8(d) (ii) & (iii), PruHealth will first give the *policyholder* notice that the *policy* is suspended for one month until the next payment date. During such a period PruHealth reserves the right to make no authorisations or payments under the *policy*. If, after that second payment date, any sums remain due, PruHealth will cancel the suspended *policy*, and reserves the right to recover any outstanding sums (which, for the avoidance of doubt, shall not include any additional premium in respect of the suspended month). Nevertheless, if any outstanding sums are paid on or before that second payment date, PruHealth may, at its discretion, reinstate the suspended *policy*.

■ (ii) If the *policyholder* instructs its bank to cancel their direct debits, once PruHealth has received notice of the direct debit cancellation from the bank, PruHealth will cancel the *policy* at the end of the *policyholder's* next *policy* month ("the Cancellation Point"). PruHealth reserves the right to recover any unpaid premiums up until the Cancellation Point.

■ (iii) PruHealth may immediately cancel this *policy* or terminate an insured person'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 with PruHealth.

4.9 Claims

The procedure for *members* to follow in making a claim is laid out in section 4.9b:

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 or go online for authorisation before any *treatment* including consultations, *outpatient*, day case 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* details will be clinically assessed);
- Whether any *pre-existing conditions* or other exclusions apply. PruHealth may request medical information from a GP/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 in Section 1 are satisfied;
- That the specialist's fees are covered by the *member's* plan, if the specialist's fee are higher than *PruHealth's fee maxima*, the *member* will be responsible for the difference; and
- 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 clinical protocols.

The *member* should have to hand:

- the details of their condition and intended *treatment*;
- their GP contact details; and
- the details of the relevant specialist or *therapist* i.e. full name, phone number, number and postcode.

For hospital *admissions*, the *member* will be given an authorisation number and target length of stay, which the hospital will require.

Where the *member* pays fees or charges, claims for reimbursement should be submitted within 6 months of the *treatment* date to be eligible.

Where the *member* does not obtain authorisation from PruHealth before being treated, they may be liable to pay all or part of the costs of *treatment*.

We are not always able to confirm at the time of authorisations 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 for 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 shall be entitled to initiate proceedings in a *member's* name for recovery of its outlay or any sums due under this *policy*. PruHealth shall 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.

4.10 Renewal

a) Plan, premium changes

i) Except for the changes listed in section 4.5, plan and premium changes will take effect only at the end of the *policy year*. Plan changes may be subject to underwriting requirements.

ii) PruHealth reserves the right to decline a plan upgrade based on the claims experience of the *policyholder* or a dependant or partner in respect of the risk of the *policy*.

iii) PruHealth will automatically renew the *policy* unless there has been fraudulent activity or the *policyholder* or *policy* dependants have misled PruHealth in any way. PruHealth will not decline renewal based on claims experience alone. Where a plan is discontinued, PruHealth will move the *member* to the closest available alternative.

b) 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 different 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 contact 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 by the *policyholder*.

At *policy* renewal, PruHealth will allocate a no claims discount per *policy* based on claims made during the *policy year*. The full twelve months of the *policy year* will be reviewed. Where late claims are received and not taken into account these will be added into the following renewal calculation. Claims made by any *member(s)* on the *policy* will be taken into account.

Any claims made with an open authorisation for a date within the *policy year* will be deemed to be a claim and be included for that *policy year*. The no claims discount will be increased by 5% for each year the *member* does not claim to a maximum of 35%. It will decrease by 10% if a claim is made in the *policy year*.

The Vitality renewal reward will also be calculated based on a *policy's* attained Vitality status in the *policy year*. The Vitality status will be based on Vitality points earned during the *policy year*.

The Vitality renewal reward will be based on a combination of the Vitality status and the monthly premium paid in the *policy* period.

Should the *policy* premium have changed over the *policy year* an average will be calculated.

The Vitality renewal reward can be paid as a tax-free cash lump sum or as a discount off the new *policy year* premium. The cash lump sum is payable only after renewal.

The *member* will need to select between a premium discount or a cash lump sum. Selection must be made within the given selection period and by the time this closes. If no selection is made the reward will fall away. The simplest way of making a selection will be via our secure online facility.

The *member* has 30 days after their renewal date in which to change their mind. They should notify PruHealth within those 30 days that they do not want their cover to continue.

During this period, if any claims are paid in respect of *treatment* during this period, the *member* will be liable for their full premium up to the end of their *policy* month. The *member* will only be able to withdraw at the start of the next *policy* month. There will be no refund in respect of any Vitality activities or Vitality points earned under a cancelled *policy*.

4.11 Other insurance

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

4.12 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 *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 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 the *member* never needs to complain, but if they do, they must please write to us at:

PruHealth Customer Services
Stirling FK9 4UE

If we cannot settle their complaint they 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 8 weeks of receiving it we will send the *member* a letter explaining why the complaint has not been resolved and confirming when we will make contact 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
Marsh Wall
London E14 9SR

Telephone: 0845 080 1800

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

Website: www.financial-ombudsman.org.uk

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 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 United Kingdom.

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 you to the state of health they were in immediately before suffering the disease, illness or injury, or which leads to their recovery. We 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 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, checkups, examinations or tests.

8.5 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* until the age of 21 years, or 24 years if in full time education.

8.6 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.

8.7 Combined limits

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

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 do 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 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 Interaction

A visit by a *member* to their healthcare provider

8.20 Member

Refers to the people including the *policyholder* who are covered under the *policy*. It may also include the partner and any dependant *members* who are covered.

8.21 Miscarriage

Loss of a pregnancy under 24 weeks' gestation.

8.22 Nurse

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

8.23 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 Out of hospital list co-payment

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

8.25 Palliative care

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

8.26 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.

8.27 PMI

Refers to private medical insurance

8.28 Policy

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

8.29 Policyholder

Refers to the person 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 previous 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 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 and 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 services (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

Contact us.

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