Vitality
HEALTH INSURANCE

YOUR PLAN TERMS AND CONDITIONS

IF YOU EVER NEED TO MAKE A CLAIM, YOU CAN DO SO ONE OF THREE WAYS:

1 

VITALITY GP APP

Use our Vitality GP app to book a private video consultation with a GP

2 

MEMBER ZONE

Submit a claim online in the Member Zone 24 hours a day, 7 days a week

3 

CALL US

Call us on the number at the top of the letter you received from us when you joined

WELCOME TO VITALITY

ABOUT THIS DOCUMENT

This document reflects the plan terms and conditions of your Corporate Healthcare plan as agreed between Vitality Health Limited (the insurer that underwrites this plan) and your employer. Please refer to this document and your certificate of insurance for full details of the cover and any exclusions that may apply.

You will also find reference to our **Vitality Programme** in this document. Please note that this may change during the course of a **plan year**. Further details can be found in 'The Vitality Programme' section of this document and Appendix 4.

ABOUT VITALITYHEALTH

VitalityHealth is owned by Discovery Holdings which was founded in 1992 as a specialist health insurance company in South Africa.

For more information visit
www.discovery.co.za

THE PURPOSE OF THIS PLAN

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

CONTACTING US

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

Online:

Via our Member Zone at **vitality.co.uk/member** and send us a secure message. By post to:

VitalityHealth Customer Services
Sheffield, S95 1DB

HOW WE WILL COMMUNICATE WITH YOU

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

ABOUT THIS PLAN WORDING

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

YOUR CERTIFICATE OF INSURANCE

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

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

Certain words used within these terms and conditions have special meaning that we'd like to draw to your attention:

We/us/our – means VitalityHealth

You/your – means the **insured member** and **insured dependants**

References to the **planholder** mean the **company** or employer which has the contract with us.

We have printed the remaining defined words in bold to help you identify them as you read through this document.

You'll find a full explanation of each word in the 'Definitions' section on page 40. If you have any queries about your plan, please speak to your Group Secretary, or call our customer services team who will be happy to help you.

SUMMARY OF COVER AND EXCLUSIONS

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

WHAT IS VITALITYHEALTH'S CORPORATE HEALTHCARE PLAN?

- Our Corporate Healthcare plan aims to cover the costs of private medical **treatment** for acute medical conditions for **UK** residents. The plan is not suitable for residents of other countries, including residents of the Republic of Ireland. Our Core Cover provides a GP consultation service, cover for **in-patient** and **day-patient hospital treatment**, and **out-patient** surgical procedures. Other cover options your employer can choose to include are:
  - **Out-patient** scans, tests and **treatment**
  - Cancer Cover
  - Mental Health Cover
  - Therapies Cover
  - Dental Cover
  - Travel Cover.

Our Corporate Healthcare plan also includes discounts and cashback that can help you lead a healthier lifestyle and reward you for doing so.

Please read the 'Your healthcare cover explained' section on page 8 together with your certificate of insurance to find out what cover you have.

HOW LONG DOES THE PLAN LAST AND HOW CAN IT CHANGE?

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

WHAT DOES THIS PLAN NOT COVER?

- Like all health insurers there are some conditions and **treatments** we don't cover. Here are some of the key ones but please refer to 'Exclusions – what's not covered' on page 19 of this document for a full list:
  - Any regular monitoring or ongoing **treatment** of chronic (long-term) medical conditions. Examples of **chronic conditions** include diabetes, multiple sclerosis and asthma
  - **Treatment** received outside the **UK**
  - Emergency **treatment**
  - **GP** consultations, except with a **Vitality GP** or a private **GP** on our provider panel
  - Pregnancy and childbirth
  - Cosmetic treatment (other than treatment we have authorised under our Lifestyle Surgery benefit)
  - Organ and whole body part transplants
  - **Treatment** not considered established medical practice in the **UK**
  - **Treatment** related to developmental problems, behavioural problems and learning difficulties such as autism, dyslexia and attention deficit hyperactivity disorder (ADHD)
  - **Treatment** for obesity (other than treatment we have authorised under our Lifestyle Surgery benefit)
  - **Treatment** provided by a consultant, therapist or complementary medicine practitioner not recognised by VitalityHealth.
- Our plans are designed to cover new conditions that arise after your cover starts with us, so you may also have exclusions personal to you that will show on your certificate of insurance, if you completed a health questionnaire.
- If you joined under our moratorium clause, any medical conditions you've had in the five years leading up to your **cover start date** are automatically excluded. These conditions can become eligible for cover if you don't consult anyone in a medical capacity, receive medical **treatment** or take medication for them or any **related conditions** for two continuous years.

Please read the section 'Exclusions – what's not covered' on page 19 for full details.

WHICH HOSPITALS ARE ELIGIBLE UNDER YOUR PLAN?

- If you have one of our hospital list options, you should only go to a **hospital** on your chosen list, as you're only covered in full for **treatment** at those **hospitals**. If you go to a hospital that's not on your list, then you'll have to pay 40% of the costs of your **treatment** (excluding your **consultants'** fees).
- Some **consultants** can arrange for **diagnostic tests** and scans to be carried out in a number of different hospitals. It is important that you check that the **hospital** your **consultant** suggests you attend is eligible on your plan.
- If your employer has chosen our Consultant Select option, you must contact us before having **treatment** so we can arrange for you to see a **consultant** on our panel. Alternatively you can make an appointment with a **Vitality GP** who will arrange for you to see a **consultant**. The **consultant** will then choose the **hospital** you are treated in. We will not pay for **treatment** we have not authorised in advance.

WHAT IS THE VITALITY PROGRAMME?

- We believe your health insurance should do more than pay claims when you're ill; it should help you lead a healthier lifestyle too.
- We'll help you improve your health by giving you discounts and cashback with our health partners. If your plan includes Vitality Plus (as stated on your certificate of insurance), to help keep you motivated, we also give you rewards for being healthy.
- Your employer may choose to upgrade your cover to include a Personal Health Fund that lets you buy services and **treatments** not usually available with health insurance.
- Because we are working with a range of partners and services that can change over time, we may change the way we award points and/or the eligible partner activities. We may change the partners and the incentives we offer from time to time. Prices with our Vitality partners may also increase during the **plan year.**

Please read the section called 'The Vitality Programme' on page 26 to find out more.
If your certificate of insurance shows you have the Personal Health Fund option, then please also read Appendix 4 called 'The Personal Health Fund'.

WHAT HAPPENS IF YOU (THE INSURED MEMBER) LEAVE THE COMPANY?

Your cover ends on your leaving date which means we won't pay for any more **treatment** you have after that date even if you're in the middle of **treatment** at the time or we've authorised that **treatment** in advance. Depending on your age and how long you've been covered under your **company** scheme, you may be eligible to continue your cover with us on an individual plan with the same personal underwriting terms. Full details can be found in section 5.7.

Please also note that you may still be subject to the notice period of any relevant Vitality partner and to any other relevant terms and conditions of that Vitality partner. Also, there will be no refund in respect of any partner activities or Vitality points earned once your cover has ended.

WHAT HAPPENS IF YOU COMPLAIN BUT ARE NOT HAPPY WITH THE OUTCOME?

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

WHAT PROTECTION IS THERE IF VITALITYHEALTH GOES OUT OF BUSINESS?

VitalityHealth is covered by the Financial Services Compensation Scheme. If we are unable to pay your claim because we have become insolvent or are no longer in business, you may be entitled to compensation.

More details about the Financial Services Compensation Scheme, including who is eligible, can be found on their website: **www.fscs.org.uk**.

YOUR HEALTHCARE COVER EXPLAINED

In this section we have set out details of the cover options and the exclusions that apply to each option. Other exclusions applying to your plan are contained within the 'Exclusions – what's not covered' section on page 19. You may also have exclusions personal to you based on your medical history. You will find details of any personal medical exclusions in your certificate of insurance.

IMPORTANT NOTES

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

- aims to cure an **acute condition** or the **acute flare-up of a chronic condition** or to return you to your state of health immediately before suffering an **acute condition** or **acute flare-up of a chronic condition**
- is given by a **consultant**, therapist or complementary medicine practitioner recognised by us and takes place at a **hospital** or other facility that is eligible under your plan
- is appropriate for your condition and established medical practice at the time of the **treatment**
- is covered by the benefits of this plan, subject to any terms and conditions.

Subject to any limits that apply, we will pay for eligible **treatment** costs after taking off any **excess** that may apply under the plan. You must always contact us before you start your **treatment** to ensure your **treatment** will be covered.

Your plan also provides you with cover for Lifestyle Surgery for some specified medical conditions. Our general exclusion for pre-existing conditions doesn't apply to the conditions covered under this benefit but there are other rules specific to this benefit. Full details can be found in Appendix 5.

THE HOSPITALS ELIGIBLE UNDER YOUR PLAN

- If you have one of our hospital list options, you should only go to a **hospital** on your chosen list, as you're only covered in full for **treatment** at those **hospitals**. If you go to a hospital that's not on your list, then you'll have to pay 40% of the costs of your **treatment** (excluding your **consultant's** fees).
- Some **consultants** can arrange for **diagnostic tests** and scans to be carried out in a number of different hospitals. It is important that you check that the **hospital** your **consultant** suggests you attend is eligible on your plan.
- If your employer has chosen our Consultant Select option, you must contact us before having **treatment** so we can arrange for you to see a **consultant** on our panel. Alternatively you can make an appointment with a **Vitality GP** who will arrange for you to see a **consultant**. The **consultant** will then choose the **hospital** you are treated in. We will not pay for **treatment** we have not authorised in advance.

WHAT HAPPENS IF YOUR COVER ENDS

This plan covers you for eligible **treatment** that takes place while the plan is still in force (in other words, whilst the plan is still active, premiums have been paid to date and it has not been cancelled or lapsed for any reason) and you are still an **insured member** or **insured dependant** of this scheme.

We do not pay for **treatment** that takes place after your cover has ended, even if this is a continuation of **treatment** that started while you were still covered by this plan, or even if we've authorised it in advance but the **treatment** is now going to take place after your cover has ended. In certain circumstances, we can offer you the opportunity to continue your cover on an individual plan without changing your **medical underwriting** terms. Please refer to paragraph 5.7 on pages 38 and 39 for more details.

YOUR COVER

The tables on the following pages show all of the cover options that can be chosen.

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

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

The column on the right called 'What's not covered' shows some of the exclusions that apply to each aspect of cover. However, a full list of exclusions is included on pages 19 to 22. Please also read the 'Important information about your cover' section which tells you more about some of the options. This section can be found on pages 23 to 25.

WHAT WE MEAN BY 'FULL COVER'

Wherever we say 'full cover' in your certificate of insurance we mean all of your eligible costs will be covered in full (unless any **excess** applies) providing you're being treated in a **hospital** or other facility that is eligible under your plan and by a **consultant** recognised by us, and we have authorised your **treatment** in advance. For example, if you need an operation our 'full cover' promise includes paying your surgeon's and anaesthetist's fees in full.

PRIMARY CARE

WHAT'S COVERED	WHAT'S NOT COVERED
Video consultations with a **Vitality GP** Face-to-face consultations with a private **GP** in our network* Charges for: • minor **diagnostic tests** ordered by a **Vitality GP** or private **GP** in our network • medication prescribed by a **Vitality GP** or private **GP** in our network (for **treatment** of an **acute condition**) **Please also see 'Important information about your cover' paragraph 1.4** *a co-payment applies to this benefit, please see your certificate of insurance for further details.	Charges for **GP** consultations not undertaken by a **Vitality GP** or private **GP** in our network **Diagnostic tests:** • not ordered by a **Vitality GP** or private **GP** in our network • ordered by a **Vitality GP**, or private **GP** in our network, at the same time as they refer you to a **consultant** Private prescription charges, where the medication is: • not prescribed by a **Vitality GP** or private **GP** in our network • a routine or repeat prescription • available from a pharmacy as an over-the-counter medication • a drug which has been prescribed during the last month (unless it is to complete a short course of **treatment**) • for protection against disease when travelling abroad (including vaccinations) • a supplement or feed (e.g. infant formulas)

PRIVATE MEDICAL HELPLINE

This is a 24 hour phone line giving you access to medical advice seven days a week, 365 days a year. You can use this service if you want advice on general health topics or you are unsure whether to seek emergency **treatment**. However, they will not have any details about you in advance, and they will not be able to refer you to a consultant or prescribe medication. If you think you require **treatment** for a specific condition, you should arrange a video consultation with a **Vitality GP** or book a face-to-face consultation with a private **GP** in our network.

HOSPITAL FEES

WHAT'S COVERED	WHAT'S NOT COVERED
Charges for **in-patient** and **day-patient treatment** at a **hospital** eligible under your plan: • accommodation, nursing, drugs given for immediate use while in **hospital**, **critical care** • operating theatre charges, surgical dressings and drugs • surgical appliances needed as a vital part of an operation • **diagnostic tests**, including pathology, radiology, CT, MRI and PET scans • **physiotherapy** (when part of **in-patient treatment** only).	• medical aids or appliances (e.g.neck collars, splints and foot supports) • mobility aids (e.g.wheelchairs and crutches) • spectacles, contact lenses, hearing aids or cochlear implants • the provision or fitting of any external prosthesis • drugs and dressings that you take home • personal expenses such as newspapers, telephone calls, additional meals.

CONSULTANT FEES

WHAT'S COVERED	WHAT'S NOT COVERED
Consultant fees for **in-patient** and **day-patient treatment** that takes place at a **hospital** eligible under your plan: • surgeons' and anaesthetists' fees for operations and surgical procedures performed as an **in-patient** or **day-patient** • physicians' fees and other **consultant** appointments.	• **treatment** given by a consultant not recognised by us.

OUT-PATIENT SURGICAL PROCEDURES

WHAT'S COVERED	WHAT'S NOT COVERED
Charges for **out-patient** surgical procedures* at a **hospital** eligible under your plan or in the **consultant's** specialist consulting rooms, where appropriate: • surgeons' and anaesthetists' fees • operating theatre charges, surgical dressings and drugs used during the surgical procedure • any other related and necessary medical **treatment** that takes place on the same day as the surgical procedure. ***Out-patient** surgical procedure means an operation or other invasive procedure carried out on an **out-patient** basis.	• scans and **diagnostic tests** • **out-patient treatment** that is not a surgical procedure • medical aids or appliances (e.g.neck collars, splints and foot supports) • mobility aids (e.g.wheelchairs and crutches) • spectacles, contact lenses, hearing aids or cochlear implants • the provision or fitting of any external prosthesis • drugs and dressings that you take home • personal expenses such as newspapers, telephone calls, additional meals • **treatment** given by a consultant not recognised by us.

PRIVATE AMBULANCE

WHAT'S COVERED	WHAT'S NOT COVERED
Charges for the use of a **private ambulance** for transfer between **hospitals**, whether NHS or private, if a **consultant** recommends it as medically necessary. **Please also see 'Important information about your cover' paragraph 1.8**	• where use of the **private ambulance** is not medically necessary.

NHS HOSPITAL CASH BENEFIT

WHAT'S COVERED	WHAT'S NOT COVERED
A cash amount payable for: • eligible **in-patient treatment** that you choose to have as a non-paying NHS patient even though you could have had the **treatment** in a private facility • eligible **day-patient treatment** that you choose to have as a non-paying NHS patient even though you could have had the **treatment** in a private facility.	• if **treatment** is not eligible under this plan • if you have already claimed a cash benefit for **treatment** of **cancer** that took place on the same day or night • if you are admitted to an NHS hospital in an emergency, no benefit will be payable for any part of the admission • if you choose to transfer to a private **hospital** for part of your **treatment**, then no benefit is payable for any of the nights you spent as a non-paying NHS patient • if you are admitted as an **in-patient** after midnight, then no benefit is payable for that first night spent in hospital.

CHILDBIRTH CASH BENEFIT

WHAT'S COVERED	WHAT'S NOT COVERED
A cash amount payable on the birth or legal adoption of a child. This benefit is payable once only per child. **Please also see 'Important information about your cover' paragraph 1.7**	• if you've not been covered under the plan for at least 10 months before the birth.

PARENT ACCOMMODATION

WHAT'S COVERED	WHAT'S NOT COVERED
The cost of accommodation for you (the **insured member**) or your insured husband, wife or partner to stay with your insured child, while they are receiving **in-patient treatment** in a **hospital** eligible under your plan. This is providing your insured child is under the eligible age specified on your certificate of insurance. **Please also see 'Important information about your cover' paragraph 1.9**	• personal expenses.

PREGNANCY COMPLICATIONS

WHAT'S COVERED	WHAT'S NOT COVERED
Charges for **in-patient** and **day-patient treatment** at a **hospital** eligible under your plan for the following conditions and directly associated complications: • ectopic pregnancy • miscarriage • missed abortion • stillbirth • post partum haemorrhage • retained placental membrane • hydatidiform mole.	• antenatal care • any complication of pregnancy or directly **related condition** that the mother is aware of at her **cover start date** • normal pregnancy and childbirth • any complications of pregnancy except for those listed • intrauterine fetal surgery and transfusions • investigations and **treatment** of recurrent miscarriages • **hospital** charges and **consultant's** fees not directly related to eligible **treatment** of the conditions listed.

CHILDBIRTH BY CAESAREAN SECTION

WHAT'S COVERED

Up to £5,000 per **plan year** for:

- hospital fees
- the charges of the surgeon and anaesthetist

for a caesarean section carried out as an **in-patient** or **day-patient** at a **hospital** eligible under your plan, in the following circumstances:

- breech presentation
- multiple births
- risk of mother to child transmission of infection
- morbidly adherent placenta
- previous stillbirth or late miscarriage
- history of three or more consecutive miscarriages
- maternal ill-health which your obstetrician confirms may be worsened by a normal delivery.

WHAT'S NOT COVERED

- antenatal care and any costs not directly related to the caesarean section
- any complication of pregnancy or directly **related condition** that the mother is aware of at her **cover start date**
- indemnity charges
- consultant call out fees
- pain management advice.

You may also claim the NHS Hospital Cash Benefit for any caesarean section undertaken as a non-paying NHS patient, subject to the limits that apply to that benefit.

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

ORAL SURGERY

WHAT'S COVERED

Charges for **treatment** at a **hospital** eligible under your plan for the following oral surgical procedures only:

- reduction of facial and mandibular fractures following an accident
- surgical removal of impacted teeth, or partially erupted teeth, causing repeated pain or infections, and complicated buried roots
- infections causing facial swelling requiring surgical drainage
- removal of cysts of the jaw
- apicectomy.

WHAT'S NOT COVERED

- elective surgery to correct conditions of the jaw bones and/or facial skeleton
- procedures to prepare for orthodontics or prosthetic surgery
- any other **dental treatment** or maxillofacial or oral surgical procedure
- **treatment** following an accident that happened before your **cover start date**
- **treatment** not provided by an oral surgeon
- **treatment** given by a consultant not recognised by us.

HOME NURSING

WHAT'S COVERED

Charges for the services of a qualified **nurse** for skilled nursing care at home. For you to qualify for this benefit, all **home nursing** must:

- immediately follow a period of **in-patient treatment** for a medical condition covered by the plan
- be certified by your **consultant** as necessary for medical (not domestic) reasons
- be skilled nursing care provided at your home, which would otherwise be provided in **hospital** as an **in-patient**
- be given by a qualified **nurse** and carried out under the direction of your **consultant**.

WHAT'S NOT COVERED

- **home nursing** following **in-patient treatment** for psychiatric and mental conditions
- **home nursing** for a **chronic condition**
- any charges for domestic or social reasons
- frail care (e.g.care received in a convalescence or nursing home, respite care and domestic support)
- **home nursing** for end-of-life or palliative care.

REHABILITATION

WHAT'S COVERED	WHAT'S NOT COVERED
This benefit provides you with up to 21 days of **rehabilitation treatment** following a stroke or serious brain injury. The **treatment** must: • immediately follow a period of **in-patient treatment** • start no more than two months after initial diagnosis or date of injury.	• **treatment** not undertaken in a rehabilitation unit at a recognised rehabilitation facility • **treatment** given or arranged by a consultant not recognised by us.

TALKING THERAPIES

WHAT'S COVERED	WHAT'S NOT COVERED
Up to eight sessions per **plan year** of mental health therapy, such as cognitive behavioural therapy (CBT) or counselling, undertaken as an **out-patient**, and arranged through our mental health panel. **Please also see 'Important information about your cover' paragraph 1.5**	• **treatment** not arranged through our mental health panel • **treatment** that, in the opinion of our mental health panel, would be ineffective for your condition • **in-patient** or **day-patient treatment** • **out-patient** consultations with a psychiatrist or **clinical psychologist**

CANCER COVER

WHAT'S COVERED

Charges for **cancer treatment**, including **in-patient, day-patient** and **out-patient treatment**, at a **hospital** eligible under your plan. We even cover eligible **treatment** at home where this would otherwise require **in-patient** or **day-patient treatment**.

There are two benefit options available for the **treatment** of **cancer**, Cancer Cover and Advanced Cancer Cover. Your certificate of insurance will show which option applies to you.

Here's a quick summary of the cover available but please refer to Appendix 3 on pages 51 to 55 for more details about this important part of your cover:

- Surgery, including reconstructive surgery
- Radiotherapy
- Chemotherapy (the use of drugs to destroy **cancer** cells)
- Biological therapy, immunotherapy and targeted therapy.

  These are substances, regardless of the size of the molecule or the manufacturing process, which either:

  - aid the body's natural defence system in order to inhibit the growth of a tumour, or
  - target the processes in **cancer** cells that help them to survive and grow

  Examples include monoclonal antibodies (MABs) and **cancer** growth blockers.

  Limits apply to biological therapy, immunotherapy and targeted therapy if you have our Cancer Cover option.
- Stem cell therapy
- **Consultants'** fees for supervising the **treatment**
- **Out-patient treatment**, including **diagnostic tests** and monitoring or follow-up consultations that are considered medically necessary
- The services of a qualified **nurse** for skilled nursing care at home, for end stage **cancer**
- Cash benefits for specified eligible **cancer treatment** that you choose to have as a non-paying NHS patient
- Donation for each day spent in a hospice.

WHAT'S NOT COVERED

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

OUT-PATIENT COVER

WHAT'S COVERED

Charges for:

- **consultant** appointments undertaken as an **out-patient** at a **hospital** eligible under your plan
- MRI, CT & PET scans undertaken as an **out-patient** at a **hospital** eligible under your plan.

Out-patient physiotherapy

We have agreed tariffs in place with a select panel of physiotherapists across the country.

Providing you contact us so we can arrange for you to see a physiotherapist on our panel, we'll cover each **physiotherapy** session in full, it won't be subject to any limits on your 'Out-patient Cover' and we'll pay the provider direct. It is not necessary to obtain a referral from a **GP** if you follow this process.

Physiotherapy arranged by your **consultant** following surgery will also be covered in full and will not be subject to any limits on your 'Out-patient Cover'.

If you arrange your own **physiotherapy**, then we'll only pay a set amount per session, it will be subject to any limits on your 'Out-patient Cover' and you'll have to pay the provider direct yourself including making up any shortfall. You can find more details of the claims process, and the amounts we'll pay if you go out of network, by going to our website.

WHAT'S NOT COVERED

- routine medical or dental checks
- routine sight and hearing tests
- medical aids or appliances (e.g.neck collars, splints and foot supports) including consultations for measurements and fittings
- mobility aids (e.g.wheelchairs and crutches and external prostheses)
- spectacles, contact lenses, hearing aids or cochlear implants
- drugs or dressings that you take home
- any tests or scans, ordered by anyone other than your **consultant**
- **GP** visits
- **physiotherapy** provided by a therapist not recognised by us.

OUT-PATIENT DIAGNOSTICS

WHAT'S COVERED

Charges for **out-patient diagnostic tests** such as pathology, X-rays, ultrasound scans and ECGs at a **hospital** eligible under your plan.

WHAT'S NOT COVERED

- routine medical or dental checks
- routine sight and hearing tests
- drugs or dressings that you take home
- any tests or scans ordered by anyone other than your **consultant**
- **GP** visits.

MENTAL HEALTH COVER

WHAT'S COVERED

Charges for **in-patient** and **day-patient treatment** in any psychiatric **hospital** eligible under your plan:

- accommodation, nursing, drugs prescribed on a ward, **diagnostic tests** and **consultants'** fees.

Out-patient treatment including:

- **consultant** appointments, electroconvulsive therapy (ECT) and **diagnostic tests**
- consultations with a **clinical psychologist** upon **GP** referral
- talking therapies where **treatment** is agreed as clinically appropriate by a **consultant** psychiatrist, or arranged through our mental health panel. These include:
  - cognitive behavioural therapy (CBT)
  - eye movement desensitisation reprocessing therapy (EMDR)
  - counselling.

Please also see 'Important information about your cover' paragraph 1.5

WHAT'S NOT COVERED

- any **treatment** not under the control of a psychiatric **consultant** except
  - **out-patient** consultations with a **clinical psychologist** upon **GP** referral
  - where **treatment** is arranged through our mental health panel
- consultations that aren't face to face (for example telephone consultations), except initial consultations with our mental health panel
- **treatment** given by a consultant not recognised by us.

THERAPIES COVER

WHAT'S COVERED

Charges for the following therapies or consultations after referral by your **GP** or **consultant**:

- **chiropractic**
- **osteopathy**
- **chiropody/podiatry**
- **acupuncture**
- **homeopathy**
- consultations with a **dietician**

  (maximum of two per **plan year**).

Please also see 'Important information about your cover' paragraph 1.6

WHAT'S NOT COVERED

- drugs or dressings that you take home
- medical aids or appliances (e.g.neck collars, splints and foot supports) including consultations for measurements and fittings
- mobility aids (e.g.wheelchairs and crutches)
- **treatment** following self-referral where you've not consulted a **GP**, unless this has been agreed by us in writing in advance of the **treatment**
- **treatment** given by a therapist or complementary medicine practitioner not recognised by us.

OVERSEAS EMERGENCY MEDICAL EXPENSES

WHAT'S COVERED

Medical expenses*

All reasonable charges for an emergency admission for **in-patient** or **day-patient treatment** at a medical facility overseas as a result of a sudden and unexpected illness or injury that arises whilst travelling outside the **UK**. **Treatment** must be undertaken by a qualified medical practitioner and in a recognised facility in the country in which it takes place.

Reasonable additional accommodation costs and travelling expenses for one person required on medical advice to remain behind with a sick or injured insured person.

Note: Cover is restricted to trips outside the **UK** of up to 90 days.

*A £50 excess applies per claim.

Our travel assistance partner runs a 24 hour emergency service on our behalf and are there to help you in the event of a serious illness or injury requiring emergency **treatment**. Their contact details can be found in your certificate of insurance if you have this cover.

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

WHAT'S NOT COVERED

- if you've gone abroad in the knowledge that you might require medical **treatment**, or against medical advice
- any illness or injury that arises after the 90th day of your trip
- if you've travelled abroad after being diagnosed with a terminal condition
- **out-patient treatment** including any **treatment** that would normally be carried out by a **GP** in the **UK**
- **out-patient** drugs and dressings including drugs bought over the counter
- **treatment** that would not ordinarily be covered under this plan if it took place in the **UK**
- **treatment** that could have waited until you returned to the **UK**

OVERSEAS EMERGENCY MEDICAL EXPENSES (CONTINUED)

WHAT'S COVERED

Repatriation/evacuation

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

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

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

* A £50 excess applies per claim.

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

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

Important notes:

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

WHAT'S NOT COVERED

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

EMPLOYEE ASSISTANCE PROGRAMME

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

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

This service includes:

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

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

PERSONAL HEALTH FUND

This is a fund that you can use to pay for everyday healthcare bills that aren't usually covered by private medical insurance. You can use it to pay for things like eye tests and dental check-ups. Every year, we pay an amount of money into your fund. All you have to do to get the Personal Health Fund is complete the online Health Review on the Member Zone each **plan year**.

The Personal Health Fund is only available to you if your **company** has chosen it and is shows on your certificate of insurance.

For more information, please refer to Appendix 4 'The Personal Health Fund (PHF)' on pages 56 to 58.

EXCLUSIONS – WHAT'S NOT COVERED

Below we've set out the exclusions that apply to this section of your plan. In addition, any consultations, complications or subsequent **treatment** related to these exclusions are also not covered.

For ease of reference, we have divided the exclusions into the following categories:

- Medical conditions
- Treatments and tests
- General exclusions.

MEDICAL CONDITIONS

We will not pay for the following:

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

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

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

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

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

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

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

For full details of how we deal with such conditions, please refer to Appendix 1 on page 47 called 'Your guide to our moratorium clause'.

b) If you or your **insured dependants** have been **medically underwritten**:

- we will not pay for **treatment** of any medical condition we specifically exclude you or your **insured dependants** for as shown on your certificate of insurance. Please refer to the section entitled 'Full medical underwriting' under 'Acceptance terms' on page 29 and to your certificate of insurance for further details.

c) If you or your **insured dependants** have transferred from another insurer with a continued moratorium:

- we will not pay for **treatment** of any medical condition or **related condition** which is excluded under our moratorium rules (under 'Acceptance terms' on page 29) applied from when your cover first started with your previous insurer. Please see your previous insurer's certificate of insurance or other relevant documentation for details of your **cover start date** with them.

d) If you or your **insured dependants** have transferred from another insurance plan with continued personal medical exclusions:

- we will not pay for **treatment** of any condition specifically excluded by your previous insurance plan. Please refer to the section entitled 'Continued personal medical exclusions' under 'Acceptance terms' on page 29 for full details.

NOTE: with regard to c) and d) above, VitalityHealth may have also placed additional personal medical exclusions to your cover when your private health insurance was transferred to us. Please refer to the section 2.3 entitled 'Continued Personal Medical Exclusions (Switch) under Acceptance terms on page 29 and your certificate of insurance for full details of any additional personal medical exclusions that may apply.

Additional exclusions that apply under this medical conditions section are below. We will not pay claims relating to:

- **treatment** of HIV/AIDS, or any **treatment** related to this
- **treatment** of **alcohol abuse** or **drug abuse**, or any addiction, and **treatment** of any related medical conditions resulting from these

- **treatment** of any self-inflicted illness or injury, or any **treatment** related to them, or **treatment** arising from attempted suicide
- **treatment** of **chronic conditions** including investigations, regular monitoring or consultations with any healthcare professional. However, we will cover **treatment** of an **acute flare-up of a chronic condition** providing this is not part of the normal recurring nature of the condition
- **treatment** to maintain your state of health or to monitor your health on a regular basis
- **treatment** for any condition or injury arising from working offshore in the extraction/ refinery of natural/fossil fuels
- **treatment** for any condition or injury arising from working in the armed forces (including the Armed Forces Reservists) whilst on active service or on exercise in the **UK** or abroad
- **treatment** for injuries arising from participation in high-risk activities. A full list of activities we consider high-risk is available on the Member Zone, or can be requested from us. Examples include motor racing, mountaineering at altitude, skydiving, and scuba diving not within your certified limits.
- **treatment**, including investigations and assessments, related to developmental problems, behavioural problems and learning difficulties including but not limited to autism, dyslexia and attention deficit hyperactivity disorder (ADHD)
- **treatment** for myopia (short-sightedness), hypermetropia (long-sightedness), astigmatism or any other refractive error or **treatment** which results from, or is in any way related to, these conditions
- **treatment** of sleep apnoea, snoring, insomnia or other sleep disorders or **treatment** which results from, or is in any way related to, these conditions
- **treatment** for obesity and associated conditions, including surgery, or **treatment** which results from, or is in any way related to, this condition (other than treatment we have authorised under our Lifestyle Surgery benefits)
- **treatment** for hearing impairment or deafness that arises as a result of any congenital abnormality, maturity or ageing. We will only pay for **treatment** for hearing impairment or deafness that arises as a result of an **acute condition** diagnosed within the previous 12 months and after your **cover start date**
- **treatment** for dermatochalasis (baggy eyes) or ptosis (drooping) of the eyelid or brow
- **treatment** to relieve the symptoms commonly associated with physiological or natural changes as a result of ageing e.g. menopause or puberty (other than treatment we have authorised under our Lifestyle Surgery benefits)
- **treatment** for complications arising from medical conditions or **treatment** not covered by us. This includes complications arising from experimental **treatment** or **treatment** received overseas
- frail care such as care received in a convalescence or nursing home, respite care, and domestic support.

TREATMENTS AND TESTS

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

- the services of a **GP**, except a **Vitality GP** or a private **GP** on our provider panel
- **diagnostic tests** that have been arranged by anyone other than your **consultant**, except minor **diagnostic tests** ordered by a **Vitality GP** or a private **GP** on our provider panel
- emergency **treatment**, by which we mean:
  - **treatment** in an Accident & Emergency unit or other urgent care centre
  - any admission to hospital that was scheduled less than 24 hours in advance,

  However, we will cover admission to **hospital** for a surgical procedure that immediately follows an **out-patient** appointment with a **consultant** providing:
  - you are referred to a **consultant** following a face-to-face appointment with a **GP**, or a video consultation with a **Vitality GP**, and
  - it was not known the admission would be required when the **consultant** appointment was booked, and
  - your **consultant** appointment does not take place in an Accident & Emergency unit or other urgent care centre, and
  - it is for **treatment** eligible under your plan

If you are already in **hospital** , we will only cover eligible **treatment** that takes place after your **consultant** has confirmed to us (at your request) that:

- your vital signs are within normal limits and have been for at least 48 hours, and
- you do not require **critical care** (for further information about critical care, please see section 1.3 on page 23)

- immediate admission to **hospital** if you have been repatriated to the **UK** in an emergency
- **treatment**, including surgery, to remove healthy or non-diseased tissue whether or not for psychological or medical reasons, (other than treatment we have authorised under our Lifestyle Surgery benefits, or for the prevention of **cancer** in the circumstances listed in Appendix 3)
- **treatment** where the primary aim is to improve appearance (cosmetic treatment), whether or not for psychological reasons, or any **treatment** that results from or relates to previous cosmetic treatment, body modifications (e.g. piercings) or reconstructive surgery. However, we will cover certain cosmetic treatments where eligible under our Lifestyle Surgery benefits. We also cover the initial **treatment** to restore function or appearance where this is needed as a direct result of an **accidental injury** (except a dental injury) or as a result of **treatment** for **cancer** that occurs after your **cover start date.** Any subsequent related **treatment** will only be covered if intended to cure an **acute condition**
- sex change/gender reassignment or **treatment** which results from, or is in any way related to, sex change/gender reassignment
- hormone replacement therapy
- **dental treatment** unless you have our Dental Cover as shown on your certificate of insurance
- regular or long-term dialysis in chronic or end-stage kidney failure
- organ and whole body part transplants
- stem cell therapy and bone marrow transplant, except where this is for the **treatment** of **cancer**
- **treatment** or drug therapy which, based on established medical practice in the **UK**:
  - is considered to be unproven, or
  - no standard treatment protocols exist, or
  - there is insufficient evidence of safety or effectiveness

However, we will consider a contribution towards a properly controlled clinical trial, or where there is clear evidence that an experimental **treatment** is effective, in certain circumstances. Please see section 1.11 on page 25 for further details.

- any **treatment** using a drug not licensed in the **UK** or the use of drugs outside the terms of their licence in the **UK**
- **rehabilitation** following **treatment**, except following a stroke or serious brain injury as shown in your benefit table
- the use of neurostimulators, or any **treatment** connected to the use of them
- **treatment** that's given solely to provide relief of symptoms including psychological support, end of life or hospice care. However, we will cover end of life **treatment** to help relieve **cancer** symptoms or the side effects of **cancer treatment**
- **in-patient** care where no medical **treatment** is being provided, such as needing help with mobility, washing or preparing meals
- any **treatment** for, related to, or arising from or as a consequence of:
  - male or female birth control including sterilisation and its reversal
  - any type of contraception
  - termination of pregnancy
  - pregnancy or childbirth, except the conditions shown in your benefits table
  - investigations into or **treatment** of infertility
  - investigations into or **treatment** of impotence or other sexual dysfunction
  - any form of human-assisted reproduction
  - any **treatment** received within three months of birth by a dependant born as a consequence of any form of human-assisted reproduction
- oral and maxillofacial surgery, except those procedures shown in your benefits table

- routine, precautionary or preventive examinations, routine hearing and sight tests, vaccinations, screenings (including screenings of familial conditions) or preventive **treatment** (but we will cover the removal of healthy tissue for prevention of **cancer** in specific circumstances. See Appendix 3 for details)
- **treatment** provided to the **insured member** or **insured dependant** by themselves or a member of their family
- any **treatment** provided by, or undertaken whilst under the care of, a consultant, therapist or complementary medicine practitioner or other clinician who is not recognised by us for the **treatment** being provided. We may not recognise a consultant who, among other reasons:
  - has had their permission to practice suspended or restricted by a professional or regulatory body, or
  - charges more than we think is reasonable compared to other consultants with a similar level of expertise.

  To become recognised by us, providers must meet our recognition criteria and agree to our terms of recognition.

GENERAL EXCLUSIONS

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

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

IMPORTANT INFORMATION ABOUT YOUR COVER

1.1. COVER LIMITS

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

1.2. EXCESSES

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

If your certificate of insurance says you have the Vitality status-linked excess, please refer to Appendix 4 on pages 56 to 58 for information.

If you have a 'per claim' **excess**, we will deduct the **excess** from the first invoice we pay (and the next invoice if any **excess** still remains). We will reapply the **excess** if your claim continues for more than one year.

If you have a 'per person per **plan year' excess**, we will deduct the **excess** from the first invoice for **treatment** taking place in the **plan year** (and the next invoice if any **excess** still remains).

You will then need to pay the **excess** amount to the relevant person, **hospital** or other facility that provided your **treatment**.

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

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

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

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

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

- consultations with a **Vitality GP** or private **GP** on our provider panel (but you will have to make a co-payment for a Face-to-Face **GP** consultation. Full details can be found on the Member Zone.)
- minor **diagnostic tests** ordered by a **Vitality GP** or private **GP** on our provider panel
- charges for medication where the prescription has been issued by a **Vitality GP** or private **GP** on our provider panel
- NHS Hospital Cash Benefit
- Childbirth Cash Benefit
- Dental Cover (if you have this option)
- Travel Cover (if you have this option – but a £50 excess applies to some sections of this cover)
- claims under our Lifestyle Surgery benefits. But you will have to contribute 25% to the cost of consultations and package of treatment (full details can be found in Appendix 5)
- claims from your Personal Health Fund (if you have this benefit).

1.3. CRITICAL CARE

We will pay for **critical care** in a private intensive care ward or private **critical care** ward that:

- follows a scheduled (planned) admission to the same hospital, for treatment covered by the plan
- is provided in a dedicated critical care area, and
- is the most appropriate setting for such treatment.

We will not pay for critical care that:

- follows an unscheduled admission
- follows treatment not covered by the plan
- is not medically necessary for the condition being treated
- immediately follows a transfer from another facility, or was likely to be required following the transfer,

unless we agree to this in advance.

1.4. PRIMARY CARE

In order to use the video consultation service, you will need access to an Apple or Android-compatible mobile phone or tablet device. The Vitality GP app is available to download for free from the App store and Google Play. Log in to the Member Zone at vitality.co.uk/member for a list of the compatible devices and minimum operating requirements.

Video consultations can be booked up to 48 hours in advance, with appointments available between 8am and 7pm Monday to Friday, and between 9am and 1pm on Saturdays.

During your consultation, the **Vitality GP** will capture information relating to your condition and the outcome of the consultation. This will be recorded securely in the app. You may choose for this information not to be shared with us. However, if you are issued with a prescription, or you are referred for further **treatment** that we cover you for, certain information will be shared with us so we can process your claim.

We reserve the right to charge £25 for each consultation that is missed, or cancelled less than four hours prior to the appointment time. Inappropriate use of the service, or aggressive or threatening behaviour towards the **Vitality GP,** may result in your access to the **Vitality GP** being withdrawn.

To book a face-to-face **GP** consultation, you will need to follow the booking process on the Member Zone. There will be a co-payment for each face-to-face **GP** consultation. Please check your certificate of insurance for details of any limits and co-payments that apply.

Should the **Vitality GP**, or a private **GP** in our network, refer you for minor **diagnostic tests**, or issue a prescription that is eligible for benefit and that you decide to fulfil at your own pharmacy, you will need to pay for these yourself. We will reimburse you from your primary care benefit, up to the limit stated on your certificate of insurance. If the prescription is fulfilled through our partner pharmacy then, providing you have sufficient benefit remaining, we will settle the bill directly.

1.5 MENTAL HEALTH COVER

Due to the nature of mental illness it may be that over the course of **treatment**, the condition will be deemed to be chronic (long-term). Where this happens, we will always give you reasonable notice before withdrawing cover so that you can make alternative arrangements.

1.6. THERAPIES COVER

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

1.7 CHILDBIRTH CASH BENEFIT

To claim this benefit you must provide us with a copy of the birth certificate and request the payment of benefit within six months of the birth, unless there is a good reason why this cannot be done.

This benefit is also payable in the case of legal adoption. To be eligible, the child must be under 18 years of age at the time of adoption and we must be informed within six months of the adoption taking place. You must also provide us with a copy of the necessary paperwork. The 10 month waiting period required before the birth of a child:

- does not apply to adoption
- can include cover with your previous insurer if your underwriting terms are continued personal medical exclusions (switch).

1.8 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.

1.9 PARENT ACCOMMODATION

This cover is to enable one insured parent to stay in the same **hospital** as your insured dependent child when your child is admitted as an **in-patient** to a private **hospital** or an NHS private ward within an NHS Private Patient Unit (PPU). Paediatric conditions are mainly treated in NHS hospitals, though some private hospitals still provide **treatment**. If your **insured dependant** goes to an NHS hospital for eligible **in-patient** or **day-patient treatment**, they are eligible for the NHS Hospital Cash Benefit. Please refer to your certificate of insurance for the age restriction that applies to this benefit.

1.10 CHILDBIRTH BY CAESAREAN SECTION

Some facilities will list the charges they make as separate items, while others offer `maternity packages' which incorporate a number of different elements of care for a single charge. In either case, if the cost of your **treatment** exceeds the benefit limit, you will need to pay the difference.

We would always recommend you talk to the **hospital** and your **consultant** about the costs of your **treatment**, and also to have your claim authorised in advance by us, so you understand what costs you will need to pay yourself.

1.11. TREATMENT THAT IS NOT ESTABLISHED MEDICAL PRACTICE IN THE UK

Our plan does not cover drugs and **treatment** that are not considered to be established medical practice in the **UK** or for which there is insufficient evidence of safety or effectiveness. This includes drugs that are used outside the terms of their licence or **treatment** that has not been reviewed and approved for general use in the NHS. However, we may consider a contribution towards the cost of such **treatment** where this is part of a properly controlled **UK** clinical trial or where we believe there is adequate evidence that the **treatment** is effective. You must contact us before undergoing **treatment** to check what we will cover.

If we agree to make a contribution towards the **treatment**, we will not:

- pay any costs if the **treatment** would in any event be excluded under the other terms and conditions of this plan
- pay more than the cost of the **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 **treatment** or for any further **treatment** you might need because of the **treatment**
- pay for any costs if there is no alternative established **treatment** in the **UK**.

THE VITALITY PROGRAMME

Vitality is insurance that rewards you for being healthy. As well as protecting you when things go wrong, it also helps you lead a healthier life – meaning you don't have to claim to be able to benefit. It's the way insurance should be.

We give you advice about keeping well, and discounts to encourage you to get healthier. If your plan includes Vitality Plus, you will also get rewards for doing healthy things.

There are discounts with our health partners, as well as useful tools to help you understand and monitor your health. As you take steps to improve your health you'll earn Vitality points which count towards your Vitality status, helping you to see your progress.

WE'LL HELP AND ENCOURAGE YOU TO LEAD A HEALTHIER LIFE BY:

1. Helping you understand your health

2. Making it cheaper and easier to get healthy

3. Rewarding you for doing healthy things

There are four statuses, Bronze, Silver, Gold and Platinum. Everyone starts at Bronze and your Vitality status is then determined by the points you build up during your **programme year**, through activities ranging from exercise and healthy eating to health screens and regular check-ups.

Your **programme year** begins again on your **programme anniversary**, which is set when your first Vitality plan begins (which could be a VitalityHealth, VitalityLife or VitalityInvest plan providing it includes the benefit of the **Vitality Programme**) and will correspond to the **annual renewal date** of the plan. Your **programme anniversary** will remain the same for as long as you continuously hold at least one Vitality plan with the benefit of the **Vitality Programme**, unless you become a dependant on a plan held by another person, in which case it might change.

The Vitality status you achieve by the end of a **programme year** will then remain for the whole of the next **programme year**, unless you improve your status.

You can improve your Vitality status by achieving the required number of points to move you from one status to the next; we call this the 'Vitality status threshold'. For example, currently you need 800 Vitality points to reach Silver status and you would need to increase this to 1,600 points to achieve Gold status. When there is more than one adult on a plan the number of points required to reach each status is increased.

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

Full details on how it all works and the benefits you could enjoy can be found in the Member Zone.

HOW THE VITALITY PROGRAMME CAN CHANGE

1. The **Vitality Programme** will change over time as new opportunities and technologies arise. They are also dependent on our relationship with third party providers and the range of services they offer.

2. We may change the way we award points and/or the eligible partner activities and the Vitality status you may achieve as a result. We may also change our Vitality partners from time to time and the incentives we offer. There may be instances where other aspects, such as particular benefits, may be significantly enhanced, changed or withdrawn.

3. These changes may occur if our Vitality partners offer additional services or become unable to maintain their levels of service to us, or where we add new Vitality partners. Changes may also be required to prevent the fraudulent use of benefits. Revisions may be required as a result of other factors beyond our control.

4. Benefits can be expressed as a straightforward Pound amount, a percentage discount off a provider's standard price, a percentage cashback on the provider's standard price or as a benefit without a specific retail value. We reserve the right to increase a straightforward Pound amount of a particular benefit during the **programme year**. If we do need to increase these prices, we will increase them for all our members at the same time, to avoid any confusion. Any price increases will only occur once during a **programme year**. No price increase shall exceed the amount equal to the change in the Consumer Price Index (since our last price increase for that benefit) as calculated against the Bronze price (or the price paid by all members if there is no difference in price according to Vitality status). For example, if the Bronze price (or standard price, if applicable) for a particular benefit is £100, and the CPI increases 3%, the maximum price increase for any Vitality status shall be £3. Therefore, if the Platinum price for that particular benefit is £10, the most someone on Platinum status would pay is £13.

5. The cost of benefits expressed as a percentage discount off a provider's standard price, or as a percentage cashback on the provider's standard price, may vary during a **programme year** if that provider changes its standard price. For example if the current discount on a benefit is 50% and the current standard price is £40, the cost to you would be £20. If the standard price was increased to £50, the cost to you would be £25.

6. We will usually tell you about any changes, including any price increases, at least six weeks before the changes take effect, unless we're unable to do so due to factors outside our control. If your employer is not satisfied with the changes, they may cancel your plan in line with the cancellation provisions in section 5.6 (page 38). However, please note that you may still be subject to the notice period of any relevant Vitality partner and to any other relevant terms and conditions of that Vitality partner.

7. Please note that the previous clause refers just to changes made within the **programme year** and does not prevent us from applying changes and price increases at the start of each new **programme year**.

8. New adult dependants or partners aged 18 years or over who join during a **programme year** may alter the Vitality status thresholds but can immediately participate in partner activities and earn Vitality points.

9. Anyone leaving Vitality before the end of the **programme year** will not be entitled to any share of benefits they may have earned during that **programme year**. All of an **insured member's** and **insured dependant's** (who are over the age of 18) Vitality benefits will cease when their cover ends subject to the notice period of any relevant Vitality partner. Also, all Vitality points they've earned will be removed from the plan and Vitality status thresholds will be adjusted accordingly. Your Vitality status may immediately go up as a result of such a change, but will not go down during that **programme year**.

10. There will be no refund in respect of any partner activities or Vitality points earned once a plan has been cancelled.

11. Unless we tell you otherwise, the limits associated with the discounts and rewards we offer will not be multiplied by the number of plans you hold with the Vitality Group. For example, if you hold an insurance plan with VitalityHealth, and another insurance plan with VitalityLife, both of which offer the same benefit, you will not get double the benefit allowance. Not all plans offered by the Vitality Group have the same discounts, cashback and rewards associated with them. Where you have more than one plan with us, your discounts, cashback and rewards will be based on the plan that, in our view, gives you the most comprehensive package of benefits

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

ACCEPTANCE TERMS

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

Knowing in advance which conditions you are covered for will normally make the claims process more straightforward, but in all cases we will need to collect information from you when you come to make a claim, and in some cases we will need further information from your **GP**.

2.1. FULL MEDICAL UNDERWRITING

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

2.2. MORATORIUM

Before starting your cover, you did not have to answer any health questions on your application form. Therefore, each claim is assessed on the information provided by you and a **GP** (or other medical practitioner) when you claim. We will not cover **treatment** of any medical condition or **related condition** which is excluded under the terms of our moratorium clause, as set out in 'Exclusions – what's not covered' starting on page 19.

You can find more information about how the moratorium works in practice by referring to Appendix 1, 'Your guide to our moratorium clause' on page 47.

2.3. CONTINUED PERSONAL MEDICAL EXCLUSIONS (SWITCH)

This is where you've been covered by another insurance plan and you (the **insured member**) applied to join us on the basis of continuing with the underwriting terms that applied to you and your **insured dependants** with that other insurance plan. Either you or the Group Secretary may also have completed a short health declaration questionnaire or application form and we accepted you on one of the following bases:

Where you were previously medically underwritten:

- either exactly the same personal medical exclusions that applied to you and your **insured dependants** under your previous insurance plan continue to apply under this plan, or
- the same personal medical exclusions applied to you and your **insured dependants** by your previous insurance plan continue to apply under this plan and additional personal medical exclusions imposed by us also apply.

Where you were previously subject to a moratorium clause:

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

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

This means no personal medical exclusions applied to your previous plan and this continues under this plan. However, the exception to this is if you or the Group Secretary were asked to complete a short health declaration or application form, in which case, depending on our assessment of the answers provided, we may have applied personal medical exclusions to your cover. If this is the case then any such exclusions will be shown on your certificate of insurance.

2.4. MEDICAL HISTORY DISREGARDED

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

Important notes about your acceptance terms:

- Please see your certificate of insurance for details of the underwriting method that applies to you
- If you, or the Group Secretary of your plan, have failed to provide full and accurate information in answer to the questions asked on application, this may mean one or more of the following:
  - we cannot cover a claim
  - we need to correct your **medical underwriting** terms by adding personal medical exclusions to you or your **insured dependants**.
  - we have to cancel your plan
  - we need to reclaim the costs of any **treatment** already paid for by us.

If you have joined us on continued personal medical exclusions terms, please note:

- the benefits, terms and conditions of this plan may be different from those of your previous plan
- we may be unable to authorise any eligible claims if we do not receive your previous insurer's certificate of insurance.

2.5 REVIEWING PERSONAL EXCLUSIONS

Personal medical exclusions can, in some cases, be reviewed in the future if you ask us to do so following a minimum of 12 months cover with us and within 30 days of your **annual renewal date** but if we require medical evidence you will have to pay for this. However, we will not review or remove any personal medical exclusion for a **chronic condition**.

CLAIMS CONDITIONS

3.1. THE COVER

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

You will see from the section headed 'Exclusions – what's not covered' starting on page 19, that we do not pay for **treatment** of **chronic conditions**. Therefore, once it is clear that a medical condition is of a chronic nature, we will stop paying **treatment** costs.

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

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

3.2 YOUR RESPONSIBILITIES

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

- Cover under this plan requires you to first obtain a referral from a **GP**. Once you have received your referral, you must contact us to obtain authorisation for your claim before starting **treatment**. You can log in to the Member Zone to start your claim, or you can call us to discuss your claim.
- If your plan includes our Consultant Select option, you should ask your **UK GP** for an open referral (i.e. not to a specific **consultant**). You must contact us to obtain authorisation for your claim, and we will arrange for you to be referred to a **consultant** or therapist on our provider panel.
- You must ensure you're registered with a **UK GP** and that, where possible, they have your full medical records. This will help avoid delay in getting authorisation for a claim by us.
- We may need your consent to obtain a medical report or a copy of your NHS medical records from your **GP**, **consultant** or another practitioner involved in your **treatment**, in accordance with your rights under the Access to Medical Reports Act 1988. If you do not give your consent, we may not be able to assess and pay your claim.
- More often than not we will be able to take claim details over the phone and authorise your proposed **treatment** at the same time.
- Sometimes, we may need you to send us a fully completed claim form to help us assess your claim. We will not pay fees charged by a medical practitioner for completing a claim form, and we will be unable to assess the claim or pay for any **treatment** before we receive the claim form.
- We may also need to request additional medical reports to monitor the progress of your **treatment**. If we do not receive the reports in a reasonable time after requesting them, we may be unable to continue paying your claim. If we need to obtain a medical report to help us assess or monitor an ongoing claim, we will pay a reasonable fee for that report.
- Before proceeding with any **treatment**, you must ensure that the **hospital** is eligible on your plan, the **consultant** or therapist is recognised by us, and that you have checked your cover and understand any payments you will need to make yourself.

PRIVATE HEALTHCARE INFORMATION NETWORK

You can find independent information about the quality and cost of private treatment available from doctors and hospitals from the Private Healthcare Information Network: www.phin.org.uk

- Unless specifically confirmed by us, you may only use the **hospitals** eligible under your plan. We reserve the right to change the **hospitals** available to you at any time, at our discretion, but this will not affect your cover if you're already receiving **in-patient** or **day-patient treatment** in a **hospital** that was available to you when that **treatment** started. We may need to amend the **hospitals** available to you if, for example, we are unable to reach agreement with an individual **hospital**, or group of **hospitals**, on their proposed charges. Log in to the Member Zone to check which **hospitals** are available to you.
- Regardless of whether your employer has chosen our Consultant Select option or one of our hospital list options, you can use the Vitality GP service to obtain your referral. They may be able to authorise your proposed **treatment** at the time of your consultation. They will also arrange a referral to the appropriate **consultant** or therapist on our provider panel. In some cases they will ask you to seek authorisation for your **treatment** from us.
- Sometimes, your **Vitality GP** may decide that you require a consultation with a **GP** in person to determine the most appropriate **treatment**, and they will ask you to make an appointment with your **UK GP.**

3.3 IF YOU'RE COVERED BY ANOTHER PLAN

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

3.4 IF SOMEBODY ELSE HAS CAUSED YOU TO CLAIM

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

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

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

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

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

If we do decide to take any legal action in relation to your plan then you and any **insured dependants** agree to reasonably assist us in pursing that legal action.

3.5 IF WE PAY TREATMENT COSTS OUTSIDE THE TERMS OF YOUR COVER

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

3.6 GENERAL CLAIMS CONDITIONS

- Any money paid to or by us will be in pounds sterling.
- We will not add interest to any money paid under the plan.
- We have arrangements in place with the **hospitals** on our lists that enable them to bill us direct for eligible **treatment**. Where this is the case, we will pay the **hospital** or person who provided your **treatment** directly.

- If you have already paid for your **treatment**, then you will need to provide us with a receipted invoice and we will then reimburse you for any eligible costs. If you do not obtain authorisation from us for your **treatment** before it takes place, we will only pay you the amount we would have paid the provider directly had we authorised the claim in advance.
- You must submit your invoices within six months of the **treatment** taking place, otherwise we will be unable to reimburse you for your **treatment**. You must also submit any claims for NHS Hospital Cash Benefit within six months of the **treatment** taking place, and any claims for Childbirth Cash Benefit within six months of the birth or adoption. If you die after paying for your **treatment** but before reimbursement to you, we will reimburse the executors of your estate.
- If an **excess** applies under your plan, we will deduct this amount from the first invoice we pay (and the next invoice if any **excess** still remains). We will tell you when we've done this and you will then need to pay the **excess** amount to the relevant person, **hospital** or other facility that provided your **treatment.**
- If we do not exercise a right or obligation under these plan terms and conditions, or if we do not enforce an exclusion against you, this does not amount to a waiver of that right or obligation by us. We will not be prevented from exercising a right or obligation, or enforcing an exclusion under your plan against you, in other circumstances.

GENERAL CONDITIONS

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

4.1. WHAT WE EXPECT FROM YOU

It is your responsibility to:

- inform us if you or any **insured dependant** are no longer resident in the **UK**
- inform us of your new address if you move house
- inform us if your contact details such as telephone numbers and email addresses change. You can update these details on the Member Zone.

4.2. PLAN CONDITIONS

The plan lasts for one year at a time. We have the right to alter the terms of your plan at each **annual renewal date** but we will always give reasonable notice of any changes. This is with the exception of your hospital list (if applicable) and the **Vitality Programme**, which we may amend at any time. For more information about the **Vitality Programme**, please read the separate section on pages 26–28.

Your plan could also change during the course of a **plan year** if there are legal, regulatory or tax changes that affect your plan.

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

Requests to change the level of cover can only be made by the **planholder** at the **annual renewal date** and, if available, any increase in cover or change to the **excess** may be subject to new underwriting terms. For example the addition of a new cover option may be subject to our moratorium clause being applied with effect from the date the benefit is added.

You cannot be insured on more than one Business Healthcare or Corporate Healthcare plan at the same time.

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

4.3 YOUR CERTIFICATE OF INSURANCE

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

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

4.4 YOUR RIGHTS UNDER THE CONTRACT

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

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

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

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

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

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

4.5 DISHONESTY/FRAUD

We believe our customers are honest, and the contract between us is based on mutual trust. Representations including statements and information provided by you or any **insured dependants** are relied on in assessing the terms of cover. In the event that any of the information provided by you or any **insured dependants** is

wrong or incomplete we may have the right to cancel cover with effect from inception and/or to decline claims made under the plan.

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

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

4.6 PAYMENTS & CURRENCY

All payments we make to you will be in pounds sterling (GBP), to a bank account registered in the **UK**. Should you need to make a payment to us, this must also be in pounds sterling from a bank account registered in the **UK**. We would normally expect you to be the registered holder of the bank account, but it can also be in the name of a person with whom you have a close personal relationship, such as a family member or close friend. We may make additional checks to establish your relationship with the account holder, and to ensure you have their agreement to make and receive payments. Please contact us if you are unsure whether the bank account is eligible.

4.7 INTERNATIONAL SANCTIONS

We will not provide cover, pay a claim or provide any benefit or payment under the plan if, by doing so, we would be exposed to any sanction, prohibition or restriction issued by, amongst others:

- The United Nations
- The **UK** Government
- The European Union

If we discover that you or any **insured dependant**, or any person paying for (or benefiting from) the plan, is subject to international sanctions, either directly or indirectly, we will immediately stop providing cover and end all benefits and payments under the plan, without any refund of premiums.

If you are, or become, aware that you or any **insured dependant** are subject to such sanctions, you must let us know immediately.

Once sanctions against you are lifted, we may be able to reinstate your plan, or you may reapply for cover under a new plan. If you decide not to continue a plan with us, any premiums that were paid, for cover after the date on which we stopped providing benefit, will be returned.

4.8 THE LAW APPLICABLE TO THIS PLAN

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

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

4.9 OUR LIABILITY UNDER THIS PLAN

Our liability under this plan is limited to paying for **treatment** or services in respect of eligible claims under this plan. The choice of provider of the **treatment** or services ("provider") for which you are claiming under this plan is your responsibility, except:

- if you are covered under our Consultant Select option, in which case your **treatment** will be provided by a **hospital**, **consultant** or therapist on our provider panel
- for Lifestyle Surgery which must be arranged through a consultant group nominated by us.

We make no representations or recommendations to you or any of your **insured dependants** regarding the availability and standard of any **treatment** or services offered or provided by any provider.

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

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

Before undergoing **treatment**, you should contact us to ensure the **treatment** is eligible under your plan, and is given by a **consultant**, therapist or complementary medicine provider recognised by us.

4.10 EVENTS OUTSIDE OUR CONTROL

We will not be liable for any delay or failure to perform our obligations under this plan if it is caused by circumstances beyond our reasonable control. Examples include:

- riot or civil commotion
- changes to the law or instructions from the regulator
- a fire, flood or storm.

MEMBERSHIP

5.1 WHO CAN BE COVERED UNDER THIS PLAN?

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

- any **employee** (including any director, partner or owner) aged 16 or over at their **cover start date**, providing they meet the eligibility criteria of this plan and as agreed with the **planholder**. They will join as an **insured member**
- the **insured member's** husband, wife or partner, who live at the same address as the **insured member** and is aged 16 or over at their **cover start date**
- the **insured member's** children (including adopted children) providing they are aged 25 or under when they first join.

Children will be removed from cover at the **annual renewal date** following their 25th birthday.

An **insured member** and their **insured dependants** must live in the **UK** for at least 180 days in each **plan year**.

Our Worldwide Travel and Overseas Emergency Medical Expenses cover is only available providing the **insured member** and their **insured dependants** are aged 79 or under when they include this option.

If any person applying to join this plan already has cover with another insurer, we recommend they do not cancel that cover until we have confirmed that we have accepted their application by issuing a certificate of insurance.

You and your **insured dependants** should ensure that you are all registered with a **UK GP** and Dentist and that they have your full medical/ dental records, if you haven't already done so. This will help avoid delay in getting authorisation for an eligible claim by us.

5.2 ADDING MORE DEPENDANTS TO THE PLAN

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

5.3 ADDING NEWBORN BABIES

If you add a newborn child to the plan as an **insured dependant**, we will add them from their date of birth, and we will not apply the exclusion for pre-existing medical conditions or require them to be **medically underwritten**. They will be accepted on medical history disregarded terms, as outlined in section 2.4, providing:

- the parent has been an insured person for at least 10 months* before the birth, and
- we receive the relevant application form from the Group Secretary within three months of the birth

*this can include cover with your previous insurer if your **medical underwriting** terms are continued personal medical exclusions (switch).

5.4 IF YOU (THE INSURED MEMBER) DIE

If you (the **insured member**) die, cover for any **insured dependants** will automatically end at midnight on the date of your death. From the date we were first informed of your death, your **insured dependant** will be allowed 30 days to contact us to apply to continue their cover with us on an individual basis, with the nearest equivalent benefits, providing they're aged 65 or under and have been insured under your **company** plan for at least two continuous years (this can include cover with a previous insurer if your scheme has switched to us).

Providing they meet those criteria and they apply within the 30 day period stated, then they can continue with the same **medical underwriting** terms that applied under this plan. Cover must be continuous from the date of your death and any existing special terms, such as personal medical exclusions, will continue to apply. They must meet the eligibility criteria for the new plan and it should be noted that the benefits, terms and conditions may be different from those of this plan. If we are not contacted within the 30 day period stated, they will have to apply for a new plan effective from a current date and with new **medical underwriting** terms.

This means that we may not cover pre-existing medical conditions and in some circumstances we may be unable to offer cover.

If they are aged 66 or over at the date on which cover would need to continue, they will have to complete a health declaration. If they can't meet the requirements of the declaration then continuation of cover will not be available and they will have to apply for a new plan effective from a current date and with new **medical underwriting** terms. This means that we may not cover pre-existing medical conditions and in some circumstances we may be unable to offer cover.

5.5 IF YOU (THE INSURED MEMBER) BECOME DIVORCED OR SEPARATED

If you (the **insured member**) have your husband, wife or partner covered on your plan and you become separated or divorced, your husband, wife or partner will no longer be eligible to be included as an **insured dependant** on this plan. You must inform us that you have become separated or divorced. Your husband, wife or partner may apply, within 30 days of the date of divorce or separation, to continue their cover with us on an individual basis and with the nearest equivalent benefits providing they're aged 65 or under and have been insured under your **company** plan for at least two continuous years (this can include cover with a previous insurer if your scheme has switched to us). Providing they meet those criteria and they join within the 30 day period stated, then they can continue with the same **medical underwriting** terms that applied under this plan. Cover must be continuous and any existing special terms, such as personal medical exclusions, will continue to apply. They must meet the eligibility criteria for the new plan and it should be noted that the benefits, terms and conditions may be different from those of this plan. If we are not contacted within the 30 day period stated, they will have to apply for a new plan effective from a current date and with new **medical underwriting** terms. This means that we may not cover pre-existing medical conditions and in some circumstances we may be unable to offer cover.

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

This means that we may not cover pre-existing medical conditions and in some circumstances we may be unable to offer cover.

5.6 IF YOUR COMPANY PLAN IS CANCELLED OR YOU LEAVE THE COMPANY

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

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

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

5.7 HOW YOU CAN CONTINUE YOUR COVER WITH US WHEN YOU LEAVE THE COMPANY

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

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

If you or your insured husband, wife or partner are aged 66 or over at the date on which cover would need to continue, then you/they will have to complete a health declaration about your/their medical history. If the requirements of the declaration can't be met, then continuation of cover will not be available and you/they will have to apply for a new plan with new **medical underwriting** terms. This means that we may not cover pre-existing medical conditions and in some circumstances we may be unable to offer cover.

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

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

DEFINITIONS

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

ACCIDENTAL INJURY

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

ACUPUNCTURE

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

ACUTE CONDITION

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

ACUTE FLARE-UP OF A CHRONIC CONDITION

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

ALCOHOL ABUSE

Alcohol dependence or hazardous drinking that results directly in harm to physical or mental health.

ANNUAL RENEWAL DATE

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

CANCER

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

CHECK-UP

A consultation with, or a visit to, any medical practitioner about any medical condition or any signs and symptoms of a medical condition. This includes attendance for an enhanced screening or monitoring programme following **cancer treatment**.

CHIROPODY/PODIATRY

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

CHIROPRACTIC

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

CHRONIC CONDITION

A disease, illness or injury that has one or more of the following characteristics:

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

CLINICAL PSYCHOLOGIST

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

Psychologists must be registered with the Health and Care Professions Council and be recognised by us.

COMPANY

The employer who has agreed with us to operate a scheme for their **employees** to cover **insured members** and **insured dependants**.

CONSULTANT

A medical or dental practitioner recognised by us:

- whose name appears on the General Medical Council or General Dental Council specialist register and has a licence to practice in the **UK**, and
- who currently holds, or has held within the past five years, a substantive, non-locum appointment of consultant or senior lecturer status in an NHS or a Defence Medical Services hospital. Alternatively, if they do not hold a substantive NHS consultant post but can provide evidence of status and clinical experience which, in the opinion of VitalityHealth, is equivalent to that required for appointment to such a post; and, who has full practising privileges in a private hospital.

COVER START DATE

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

CRITICAL CARE

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

DAY-PATIENT

A patient who is admitted to a **hospital** or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.

DENTAL TREATMENT

Dental procedures undertaken by your dental practitioner which are clinically necessary for the maintenance and/or restoration of oral health and are provided in accordance with accepted standards of dental practice.

DIAGNOSTIC TESTS

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

DIETICIAN

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

DRUG ABUSE

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

EMPLOYEE

A person engaged for reward by the **planholder** on a contract of service for a minimum of 15 hours per week and subject to PAYE.

EXCESS – PER CLAIM

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

The maximum amount you will have to pay each time you or your **insured dependants** make a new claim for **treatment** covered by this plan. If **treatment** for the same condition has gone on for more than a year, we will treat it as a new claim for any further **treatment** after the anniversary of the claim and a further excess will be applied.

EXCESS – PER PLAN YEAR

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

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

GP (GENERAL PRACTITIONER)

A medical practitioner who is registered and licensed with the General Medical Council and whose name appears on the GP register.

HOME NURSING

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

HOMEOPATHY

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

HOSPITAL

Any private hospital, or private wing of an NHS hospital, that is included on your hospital list, or which we have agreed in advance you can attend.

IN-PATIENT

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

INSURED DEPENDANT

Your (the **insured member's**) insured husband, wife or partner, aged 16 or over, who lives at the same address as you.

Your (the **insured member's**) insured children (including adopted children) aged 25 or under at their **cover start date**.

On Corporate Healthcare plans, insured children will be removed from cover at the **annual renewal date** following their 25th birthday.

INSURED MEMBER

Any qualifying **employee**, director, business partner or business owner associated with the **company** who we accept to cover.

MEDICALLY UNDERWRITTEN/MEDICAL UNDERWRITING

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

NURSE

A qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number. Any **treatment** they provide must be under the supervision of a **consultant** recognised by us.

OSTEOPATHY

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

OUT-PATIENT

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

PHYSIOTHERAPY

Treatment carried out by a person who is registered with the Health and Care Professions Council (HCPC) as a physiotherapist and who is recognised by us.

PLAN START DATE

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

PLAN YEAR

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

PLANHOLDER

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

PRIVATE AMBULANCE

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

PROGRAMME ANNIVERSARY

The date each year that is set when your first Vitality plan begins (which could be a VitalityHealth, VitalityLife or VitalityInvest plan providing it includes the benefit of the **Vitality Programme**) and will correspond to the **annual renewal date** of the plan. Your programme anniversary will remain the same for as long as you continuously hold at least one Vitality plan with the benefit of the **Vitality Programme**, unless you become a dependant on a plan held by another person, in which case it might change.

PROGRAMME YEAR

A period of 12 months starting on the **programme anniversary** date each year.

REHABILITATION

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

RELATED CONDITION

Any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury. It may also be known as an `underlying cause' or `condition arising therefrom.'

TREATMENT

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

UK

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

VITALITY GP

A medical practitioner who you contact using our dedicated advice line or Vitality GP app.

VITALITY PROGRAMME

A programme offered in conjunction with certain Vitality plans which provides ways to understand your health, help you get healthier and, if your plan includes Vitality Plus, reward you for doing healthy things.

COMPLAINTS PROCEDURE

OUR COMMITMENT TO YOU

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

HOW TO CONTACT US

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

Or you can write to us at:

VitalityHealth Customer Services
Sheffield, S95 1DB

HOW WE WILL DEAL WITH YOUR COMPLAINT

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

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

WHAT TO DO IF YOU ARE STILL NOT HAPPY WITH THE OUTCOME

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

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

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

The Financial Ombudsman Service, Exchange Tower, London, E14 9SR

Enquiry line: **0800 023 4567**

Website: **www.financial-ombudsman.org.uk**

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

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

OTHER IMPORTANT INFORMATION

YOUR RIGHTS UNDER THE FINANCIAL SERVICES COMPENSATION SCHEME

VitalityHealth is covered by the Financial Services Compensation Scheme. If we are unable to pay your claim because we have become insolvent or are no longer in business, you may be entitled to compensation.

More details about the Financial Services Compensation Scheme, including who is eligible, can be found on their website: **www.fscs.org.uk**.

VITALITYHEALTH DATA PROTECTION NOTICE

Why should you read this notice?

We think it is important for all of our members to be made aware of what information Vitality holds about them and to have the reassurance of knowing that we comply with data protection legislations. The following is a summary of our Privacy Policy. For details of the full Privacy Policy please visit **vitality.co.uk/privacy**.

Who Vitality are

Vitality is part of the Discovery Group of companies and is owned by Discovery Limited, a financial services firm based in South Africa.

Vitality Corporate Services Limited is an authorised intermediary of Vitality Health Limited ("VitalityHealth"), Vitality Life Limited ("VitalityLife") and ("VitalityInvest"). Together Vitality arranges and administers products provided by VitalityHealth, VitalityLife and VitalityInvest. Vitality Corporate Services Limited is the data controller for the management of interactions between us and you; Vitality Health Limited and Vitality Life Limited respectively are the data controllers for the personal data and special category data that you or your representative provide to us.

Sharing your personal data

We may need to share your personal data for legal or regulatory purposes, with your authorised representative where you have appointed an insurance or financial adviser or with other companies in order to provide our products and services.

Processing claims

In the event of a claim we may require a medical report from your GP. Such a report will only be requested with your consent and will be in compliance with the Access to Medical Reports Act 1988 ('AMRA'). The information requested from your GP will be limited to only the information relevant to your claim. You have the right to request to see the GP's report and to request any amendments be made by the GP where you consider the data to be inaccurate. The GP may agree to this at his/her discretion. You will be informed about the AMRA process at the time we request your consent to enable us to ask your GP for a report.

We may have to give some information about your plan and about your health or medical status to those involved in your treatment or care, (and/or your representative if you have consented to us doing this). Any such disclosure will be done confidentially unless you specifically instruct us otherwise.

If the claimant is aged 13 or over we will address any correspondence to the claimant in order to protect their right to confidentiality. The principal member will be informed only that a claim has been made and the value of the payment we have made; no details about the medical condition or treatment provided will be disclosed to them. If the claimant wishes to waive their right to confidentiality they should inform us at the time the claim is made.

If you have another insurance plan that covers the same costs that you are claiming from us, then we may also disclose your relevant personal data to that other insurer so that we can ensure we only pay our proportion of the claim.

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

Group plans

If you belong to a group plan you may want to ask your employer whether an insurance or financial adviser or other representative has been appointed, so that you know who may have access to your personal data. We may disclose information about a claim to the administrator/ Group Secretary of a group plan, but no medical information will be provided without your consent.

Marketing

Vitality Corporate Services Limited would like to send you information about our products and future products, which currently include health and life insurance, investments and general insurance. We are focused on bringing exciting new products to you and to enhance those already available by offering improved services and benefits as a Vitality member.

When you purchase a product from Vitality you will be provided with access to the Member Zone where you can manage your marketing preferences and choose your preferred method of receiving information about our products, services and the benefits at any time.

Data protection complaints

We want all of our members to be happy with the way their personal data, health data and medical information has been processed by us. If you are unhappy about the way we have managed your personal data, we would like to know about it as we are constantly striving to ensure we do the right thing and we would like to be able to put things right.

You'll find the contact details for our complaints teams at: **vitality.co.uk/legal/complaints**.

However, if you are still dissatisfied you have the right to contact the Information Commissioner, who regulates compliance with data protection regulation and laws at: **ico.org.uk**.

You can also call the ICO on **0303 123 1113** or **01625 545 745**, or write to them at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

If you have any queries in respect of your data protection rights or the way your personal data is processed by Vitality, please call us on **0207 133 8600**, or write to us at:

Data Protection Officer
Vitality
70 Gracechurch Street
London
EC3V 0XL

All information about data protection and privacy can be found at **vitality.co.uk/privacy**.

IMPORTANT REGULATORY INFORMATION

VitalityHealth is a trading name of Vitality Health Limited and Vitality Corporate Services Limited. Vitality Health Limited, company registration number 05051253, is the insurer that underwrites this insurance plan. Vitality Corporate Services Limited, company registration number 05933141, acts as an agent of Vitality Health Limited and arranges and provides administration on insurance plans underwritten by Vitality Health Limited.

Registered office at 3 More London Riverside, London, SE1 2AQ. Registered in England and Wales.

Vitality Corporate Services Limited is authorised and regulated by the Financial Conduct Authority. Financial Services Register number: 461107. Vitality Health Limited is authorised by the Prudential Regulation Authority and is regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Financial Services Register number: 400057.

You can check our authorisation on the Financial Services Register by visiting the Financial Conduct Authority's website: **register.fca.org.uk**.

THE PRODUCTS WE OFFER

Vitality Corporate Services Limited only offers insurance products from Vitality Health Limited and Vitality Life Limited. A list of the products offered is available on request. Vitality Corporate Services Limited only offers private medical insurance products underwritten by Vitality Health Limited.

APPENDIX 1

YOUR GUIDE TO OUR MORATORIUM CLAUSE

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

WHAT IS THE PURPOSE OF VITALITYHEALTH'S MEDICAL INSURANCE PLANS?

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

WHAT ABOUT PRE-EXISTING MEDICAL CONDITIONS?

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

HOW DO YOU EXCLUDE PRE-EXISTING MEDICAL CONDITIONS FROM COVER?

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

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

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

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

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

THIS CLAUSE CAN EASILY BE BROKEN DOWN INTO THREE PARTS:

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

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

What is a 'related condition'?

A **related condition** is any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury. It could be deemed to be an underlying cause of, or directly caused by, another medical condition. For example: high blood pressure and heart disease; recurrent sore throats and tonsillitis.

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX 2

CHRONIC CONDITIONS INFORMATION

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

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

WHAT IS A CHRONIC CONDITION?

A '**chronic condition**' is a disease, illness, or injury that has at least one or more of the following characteristics:

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

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

However, there are certain medical conditions that can end up needing regular consultations and **treatment** over a long period of time. These are the kinds of conditions which we, and the medical profession, usually refer to as **chronic conditions**. We will normally not cover **treatment** of a **chronic condition** if the purpose of the **treatment** is just to control the symptoms.

WHAT DOES THIS MEAN IN PRACTICE?

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

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

(*providing your plan covers these)

WHAT IF YOUR CONDITION GETS WORSE?

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

If your condition gets worse and you suffer an **acute flare-up of a chronic condition**, then we may cover the **treatment** necessary to return you to the state of health you were in before your condition worsened. Examples of when **treatment** would be covered are explained in the next section.

EXAMPLES OF CHRONIC CONDITIONS

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

Example 1

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

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

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

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

Example 2

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

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

Eighteen months later, Eve has a bad asthma attack.

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

Example 3

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

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

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

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

Example 4

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

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

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

APPENDIX 3

OUR CANCER COVER EXPLAINED

The following table gives more information about our cover for **cancer** so that you can fully understand this important part of your plan. There are two levels of cover for **cancer**, 'Advanced Cancer Cover' and 'Cancer Cover'. The details given below are based on the 'Advanced Cancer Cover' but we show where the cover differs for 'Cancer Cover'. You will need to check your certificate of insurance to find out which level of cover you have and any limits that apply.

WHERE ARE YOU COVERED FOR TREATMENT?

WHAT'S COVERED	WHAT'S NOT COVERED
• You're covered for charges for eligible **treatment** at any **hospital** or specialist **cancer** unit that is eligible under your plan • If the specific course of private **treatment** recommended by your **consultant** is expected to cost in excess of £100,000, we reserve the right to direct you to a specific hospital or facility for that **treatment** • You're also covered for charges for eligible **treatment** at home that would otherwise have to be delivered in **hospital** providing this is given by suitably qualified medical staff recognised by us • We pay a charitable donation of £75 for each day spent in a hospice for end stage **cancer**.	• As with all other **treatment**, you will have to pay a contribution towards your costs if you choose to be treated at a hospital or other facility that's not eligible under your plan.

WHAT DIAGNOSTIC TESTS ARE YOU COVERED FOR?

WHAT'S COVERED	WHAT'S NOT COVERED
• You're covered for charges for **diagnostic tests** arranged by your **consultant** and for associated consultations with your **consultant**. You're also covered for charges for CT, MRI and PET scans that take place in a **hospital** or specialist **cancer** unit eligible under your plan. ***Important note: Where it is unclear that diagnostic tests and associated consultations are cancer-related then the cost of these will initially come out of any 'Out-patient Cover' you may have. Once there is a confirmed diagnosis of cancer then these costs will be removed from your 'Out-patient Cover' and will be set against your cancer benefits.***	• **Diagnostic tests** arranged by anyone other than your **consultant** • Any **diagnostic tests** or **treatment** not considered clinically appropriate within the **UK** • Genetic tests that are designed to find out how susceptible you are to getting **cancer** (but with our Advanced Cancer Cover we do offer a discount on risk assessments for some types of **cancer**) • Normal preventive screens (but with our Advanced Cancer Cover we do offer discounts on screens for certain types of **cancer**) • As with all other **treatment**, you will have to pay a contribution towards your costs if you choose to be treated at a hospital or other facility that's not eligible under your plan.

WHAT TYPES OF SURGERY ARE YOU COVERED FOR?

WHAT'S COVERED	WHAT'S NOT COVERED
• You're covered for charges for surgery used for diagnostic reasons as well as surgery to remove a **cancer** (tumour).	• Surgery that is not considered established medical practice in the **UK**, though we may make a contribution towards the costs where this is in place of established **treatment** (see section 1.11 on page 25 for further details) • **Treatment** given by a consultant who is not recognised by us.

WHAT DRUG THERAPIES ARE YOU COVERED FOR?

WHAT'S COVERED

Charges for drug therapies includes the following:

- Charges for chemotherapy (the use of drugs to destroy **cancer** cells), including anti-sickness drugs and oral chemotherapy prescribed by an oncologist
- Charges for hormone therapy and bisphosphonates therapy.

  'Cancer Cover' exception:

  Under 'Cancer Cover', there are no time limits on hormone therapy and bisphosphonates therapy when combined with chemotherapy. Cover is restricted to three months if they are prescribed on their own. This limit applies for the whole of the time you are covered by us (whether under this plan or any other plan with us)
- Charges for biological therapy, immunotherapy and targeted therapy.

  These are substances, regardless of the size of the molecule or the manufacturing process, which either:

  - aid the body's natural defence system in order to inhibit the growth of a tumour, or
  - target the processes in **cancer** cells that help them to survive and grow

  Examples include monoclonal antibodies (MABs) and **cancer** growth blockers

  'Cancer Cover' exception:

  *Under 'Cancer Cover', cover for the use of any biological therapy, immunotherapy or targeted therapy, or combination of these, is limited to 12 months from when you first start to receive this **treatment**. This limit applies for the whole of the time you are covered by us (whether under this plan or any other plan with us).*

WHAT'S NOT COVERED

- The use of drugs outside the terms of their licence
- Any drugs that would normally be prescribed by a **GP**
- Unproven drugs where there is no evidence of their effectiveness
- Personal expenses
- Any **treatment** not considered clinically appropriate within the **UK**.

ARE YOU COVERED FOR PREVENTIVE TREATMENT?

WHAT'S COVERED

Advanced Cancer Cover only:

- Charges for the removal of healthy tissue or organs in order to prevent the occurrence of **cancer** will be covered in full, in the following circumstances:
  - you have been covered on the plan for a continuous period of three or more years, and
  - you have been identified as being at very high risk of developing **cancer** in the affected tissue or organ, either through an assessment of family history, or a genetic test, or both, and
  - you have received genetic counselling to help you arrive at your decision, and
  - your **consultant** supports the choice you have made
- For preventive **treatment** we reserve the right to direct you to a specific facility for your **treatment**.

WHAT'S NOT COVERED

Our plans are primarily designed to help diagnose and treat an eligible condition where symptoms have occurred after your cover started. This means we don't cover:

- normal screening such as breast screens
- genetic tests to see if you're susceptible to a certain type of **cancer**
- **treatment** such as surgery to remove a breast where this is done solely to prevent the development of breast **cancer** because a genetic test or family history have shown a significantly greater risk of developing the disease
- vaccines such as the vaccine given to prevent cervical **cancer**.

However, with our Advanced Cancer Cover, we do offer discounts on risk assessments for some types of **cancer**. Details can be found on the Member Zone.

We also don't cover:

- preventive surgery in cases where it is not clear there is a very high risk of developing **cancer** in the affected tissue or organs
- **treatment** provided by a consultant not recognised by us.

ARE YOU COVERED FOR RADIOTHERAPY?

WHAT'S COVERED	WHAT'S NOT COVERED
• Charges for radiotherapy are covered at a **hospital** eligible under your plan, including when given for pain relief.	

ARE YOU COVERED FOR END OF LIFE CARE?

WHAT'S COVERED	WHAT'S NOT COVERED
• Yes, we cover charges for care received solely to relieve pain and other symptoms at the end stage of **cancer**. **Advanced Cancer Cover only:** • You will be covered for the charges for a qualified **nurse** for skilled nursing care at home, up to a maximum of £1,000 per day for no more than 14 days.	• The cost of personal care services, home adaptation or the supply of special bedding or other equipment.

WHAT COVER DO YOU HAVE FOR MONITORING YOUR CONDITION AFTER YOU HAVE FINISHED YOUR TREATMENT?

WHAT'S COVERED	WHAT'S NOT COVERED
• We will cover charges for medically necessary follow-up tests at a **hospital** eligible under your plan, and **consultant** appointments needed to monitor your condition. There is no time-limit on the cover available for follow-up consultations, providing your plan remains in force. **'Cancer Cover' exception:** *Under 'Cancer Cover', medically necessary follow-up tests at a **hospital** eligible under your plan, and **consultant** appointments needed to monitor your condition, are covered for a maximum period of five years from the last date of surgery, chemotherapy or radiotherapy.*	

WHAT BENEFITS ARE AVAILABLE IF YOU HAVE YOUR TREATMENT ON THE NHS?

WHAT'S COVERED	WHAT'S NOT COVERED
• We will pay you a cash amount when you choose to have the following **treatment** as a non-paying NHS patient, even though you could have had the **treatment** in a private facility: – £100 for each night you spend in hospital receiving **treatment** for **cancer** – £100 for each day you are admitted to hospital as a **day-patient** for **treatment** of **cancer** – £100 for each day on which you attend hospital for radiotherapy (including your planning session), chemotherapy, biological therapy, immunotherapy or targeted therapy, related to the **treatment** of **cancer** The maximum amount payable is £100 per person for any single day or night, and £10,000 per person in any **plan year**.	• **Treatment** not eligible under your plan. • Cash payments for any **treatment** not listed. • Cash payments for any **treatment** not undertaken as a non-paying NHS patient. • If you have claimed an NHS Hospital Cash Benefit for **treatment** taking place on the same day.

WHAT OTHER TYPES OF TREATMENT ARE YOU COVERED FOR?

WHAT'S COVERED

We will also cover charges for:

- stem cell therapy
- initial reconstructive surgery necessary following surgery to remove a tumour
- new drugs or other **treatments** where, even though they may not have been reviewed or recommended by NICE, there is adequate evidence of their effectiveness

Advanced Cancer Cover only:

- charges for medication prescribed by your **consultant** for you to take at home immediately following **in-patient** or **day-patient treatment** in **hospital**
- **i**nitial reconstructive surgery necessary following the removal of healthy tissue for preventive reasons, that is eligible under the plan
- scalp cooling **treatment** to minimise hair loss during chemotherapy and radiotherapy
- wigs and restyling of wigs, up to a maximum of £300 per condition
- mastectomy bras up to a maximum of £200 per condition
- external prostheses and associated costs up to a maximum of £5,000 per condition

WHAT'S NOT COVERED

- More than one reconstructive surgical operation to the same part of the body. The initial surgery must also take place within five years of the original surgery
- Surgery to correct a reconstruction, except complications immediately following the initial surgery
- Alternative/complementary therapies (unless you have the 'Therapies Cover' option as shown on your certificate of insurance)
- Medical aids or appliances
- Mobility aids (e.g. wheelchairs and crutches)

HOW OUR CANCER COVER WORKS IN PRACTICE

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

Example 1

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

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

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

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

Example 2

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

*We will cover both the eligible **treatment** of new **cancers** and the **treatment** of complications of **cancer** and/or secondary **cancers**. So we would pay for the cost of Cara's mastectomy and the course of radiotherapy and chemotherapy in full. We will also cover the cost of any associated follow-up consultations where medically necessary (but limited to five years under our 'Cancer Cover').*

Example 3

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

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

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

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

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

Example 4

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

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

APPENDIX 4

THE PERSONAL HEALTH FUND (PHF)

How the PHF works

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

YOU START OFF ON BRONZE	£75
WHEN YOU REACH SILVER	ADD £50
SILVER	£125
WHEN YOU REACH GOLD	ADD ANOTHER £50
GOLD	£175
WHEN YOU REACH PLATINUM	ADD ANOTHER £50
PLATINUM	£225

So, the maximum PHF available in the first **plan year** is £225 per adult **insured member** and **insured dependant** over the age of 18. In the second and subsequent **plan years**, when you complete your Health Review you start again with £75 but you can also add any of your PHF that you didn't use in your previous year.

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

a) Optical – You can use your PHF for sight test fees, fitting fees, spectacles, lenses, spectacle frames, contact lenses, spectacle repairs, prescription swimming or diving goggles and prescription sunglasses

b) Dental – You can use your PHF for **check-ups** and **treatment** at a **UK** dentist. **Treatment** can include braces, fillings, crowns and bridges, plus hygienist fees

c) Health screens – You already get a 50% discount for our approved health screens and you can use your PHF towards the rest of the cost of a health screen with an approved partner

d) Private **GP** costs – You can use your PHF for face-to-face consultations with a private **GP** or private walk-in centre. Cover includes minor **diagnostic tests** undertaken by the private **GP**

e) Chronic prescription benefit – If you have a chronic condition that needs a regular prescription, you can use your PHF for a prescription pre-payment certificate (either 3 or 12 months certificates)

f) Activity tracking – you can use your PHF to pay up to £100 towards any activity tracking device accepted by Vitality for the awarding of Vitality points (except smart phones and Apple Watch). Each **insured member** and **insured dependant** over 18 can make one claim every three **plan years**

g) Key health indicators – you can use your PHF to claim back up to 50% of the cost of certain devices used to measure key health indicators (e.g blood pressure cuffs). Log into the Member Zone for a full list of eligible devices and limits

h) Medical aids – you can use your PHF to claim back up to 50% of the cost of certain medical aids, including hearing aids, first aid kits and dressings. Log into the Member Zone for the full list of eligible products and limits.

Important notes about the Personal Health Fund (PHF)

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

- When assessing whether you have sufficient funds available to cover your claim, we use the fund balance as at the date of your **treatment** or – where no **treatment** has been provided – the date of purchase. If the amount in your fund increases after the date of **treatment** or purchase, you will not be able to use these funds retrospectively
- Any **treatment** or product for which a claim is made under the PHF must be for the use of the **insured member** or their **insured dependants**
- Any unused part of your PHF will carry over into the next **plan year**, providing your scheme renews with this benefit
- There is a maximum retained balance of £1,000 per adult on the plan. This means that if you are the only adult on your plan then the maximum PHF you can hold will be £1,000, if there are two adults on your plan, the maximum PHF you can hold is £2,000, and so on
- Once your PHF reaches this level, no further additions to your fund will take place, until such time as your PHF reduces below this level. If your plan renews or you achieve a Vitality points threshold that makes you eligible for an addition to your PHF, the amount that is added will depend on your balance at the point you become eligible for that addition. No additions will be made retrospectively if you subsequently make a claim on your PHF
- The PHF may be withdrawn from any **annual renewal date** if your scheme no longer meets the eligibility criteria for this option or if your employer chooses to withdraw it. In these circumstances any unused funds in your PHF will be lost. The same applies if your scheme is cancelled or when your own cover ends
- You cannot take any part of your PHF as cash; it can only be used to pay for eligible benefits that are available at the time
- Sometimes your PHF may only be sufficient to part-pay for your chosen benefit and you will have to make up any difference
- If you add an **insured dependant** aged 18 or over partway through a **plan year**, then they shall be entitled to a proportion of the PHF, at the Vitality status you've achieved at the time they join, based on the length of time left to the end of the **plan year**
- If an adult dependant leaves the scheme partway through a **plan year** then, even though this might affect your Vitality status, any remaining funds in your own PHF will remain untouched.

Vitality status-linked excess

Please check your certificate of insurance to see if you have one of these options, as it must be selected by your employer.

The Vitality status-linked excess is a great way of rewarding you for improving your Vitality status. Here's how it works:

There are two options available. You start off with an **excess** of either £250 or £150. The **excess** may be 'per claim' or 'per person per **plan year**' and you will need to check your certificate of insurance to find out which one it is.

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

EXCESS LEVEL			
BRONZE	**SILVER**	**GOLD**	**PLATINUM**
£250	£100	No excess	No excess
£150	£100	£50	No excess

Important notes about Vitality status-linked excess

- We'll use your Vitality status at the time you first start your **treatment** to work out what **excess**, if any, is applicable
- If there's a delay in recording your Vitality points for any reason and it turns out that your status was actually higher at the time of your first **treatment**, then we'll use that higher status to work out your **excess**, if any
- It is your responsibility, and is in your best interests, to record your point scoring activities to ensure you get the maximum benefit
- If your Vitality status reduces at an **annual renewal date** because you've not maintained the Vitality status you'd achieved in the previous **plan year**, then any claim after that renewal will be subject to the **excess** that applies for the lower Vitality status

- The Vitality status-linked excess may be withdrawn from any **annual renewal date** if your scheme no longer meets the eligibility criteria for this option or if your employer chooses to withdraw it. If this happens, then any new **excess** agreed with your employer will apply from the relevant **annual renewal date**. In the absence of any specific instruction from your employer about their choice of **excess**, then we'll automatically apply an **excess** of £250 per person per **plan year**. This **excess** would be payable on the first invoice received for costs incurred in the new **plan year**. Please always refer to your latest certificate of insurance to find out what **excess** applies.

APPENDIX 5

LIFESTYLE SURGERY BENEFITS

This appendix gives more information about our cover for certain types of lifestyle and corrective surgical procedures that are not normally covered by private medical insurance. This cover has additional eligibility criteria and conditions and it is important that you fully understand this important part of your plan.

What benefits are covered under Lifestyle Surgery?

Severe obesity is a very serious health condition that increases your risk of many different conditions, including diabetes and heart disease. Weight loss surgery is sometimes recommended to help treat severe obesity when other non-surgical treatments have failed. We will offer three types of weight loss surgery – gastric banding, gastric bypass and gastric sleeve – where it is clinically necessary and meets our eligibility criteria to help treat severe obesity.

Some conditions affecting young people may cause emotional and psychological distress. Where it is clinically recommended and meets our eligibility and age criteria, we will offer treatment to help treat port wine birthmarks on the face, surgical ear reshaping (otoplasty), surgical breast reduction and surgical treatment to correct excessive male breast tissue (gynaecomastia).

Who will carry out the surgery?

We have contracted with a number of consultant groups to provide an initial consultation, all necessary tests and treatment for eligible members. These consultant groups will ensure you see the right **consultant,** with the right skills for your surgery. They will manage your treatment plan every step of the way.

This benefit will not be available if carried out by anyone other than a **consultant** arranged by a consultant group nominated by us.

What are the eligibility criteria?

You will not be eligible until 12 months have elapsed from your **cover start date**. If new members join a scheme they will not be eligible until 12 months have elapsed from their **cover start date.** No underwriting or personal exclusions will apply but the following tables set out the individual eligibility criteria that apply.

WHAT ARE THE ELIGIBILITY CRITERIA?

PROCEDURES COVERED	TO BE ELIGIBLE?	WHAT IS NOT ELIGIBLE?
Weight loss surgeries **Gastric banding** **Gastric bypass** **Gastric sleeve**	**Insured members** and/or their **insured dependants** must be 18 years of age or over at the start of treatment and: • Have a Body Mass Index (BMI) equal to or above 40 kg/m2; or • Have a BMI 35 – 40 kg/m2 and been diagnosed with at least one of the following conditions: – Coronary artery disease – Type 2 diabetes mellitus – Obstructive sleep apnoea (OSA) – Obesity hypoventilation syndrome (OHS) – Pickwickian syndrome – NAFLD or non-alcoholic steatohepatitis – Hypertension – Dyslipidaemia – Venous stasis disease • The procedure must be arranged by the consultant group nominated by us.	**Insured members** and/or their **insured dependants**: • With reversible endocrine or other disorders that can cause obesity; or • Receiving **treatment** for drug or alcohol addiction or where there is evidence of current **drug abuse** or **alcohol abuse**; or • With uncontrolled, severe psychiatric illness; or • Who have previously had the same or similar procedure.

WHAT ARE THE ELIGIBILITY CRITERIA?		
PROCEDURES COVERED	**TO BE ELIGIBLE?**	**WHAT IS NOT ELIGIBLE?**
Removal of port wine birthmarks on the face	• **Insured dependants** must be under 5 years of age at the start of treatment • The procedure must be arranged by the consultant group nominated by us.	• More than 10 treatments in total • **Insured dependants** who have previously had the procedure
Ear reshaping (pinnaplasty)	• **Insured dependants** must be aged 5 to 14 years (inclusive) at the start of treatment • The procedure must be arranged by the consultant group nominated by us.	• **Insured dependants** who have previously had the procedure
Breast reduction including treatment for excessive male breast tissue (gynaecomastia)	• **Insured members** and/or their **insured dependants** must be under 21 years of age at the start of treatment; and • Have a BMI less than 27 kg/m2 • The procedure must be arranged by the consultant group nominated by us.	• **Insured members** or **insured dependants** who have previously had the procedure

All surgery must be agreed as clinically necessary by a **consultant** arranged by the consultant group nominated by us.

Where is this surgery carried out?

If you have selected one of our hospital list options, this does not apply to the Lifestyle Surgery benefit. The consultant group nominated by us will make the arrangements for treatment at a facility near you, where possible. Some facilities may be close to where you live but gastric banding and bypass may only be available at one site in London.

Cover under the Lifestyle Surgery benefit will not be available if treatment is not arranged by the consultant group nominated by us.

Will I have to contribute to the cost of this surgery?

Yes. You will be required to make a contribution towards the cost of your treatment of 25% of the package price agreed by the consultant group. This includes the initial consultation fee.
The package price will include all **in-patient** charges, surgeon's and anaesthetist's fees and clinically necessary follow-up appointments with the **consultant** and, if necessary, a **dietician**. You will be provided with details of the package price on application to the consultant group.

No **excess** applies to this benefit.

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FIND OUT MORE

For more information please speak to your adviser or visit our website vitality.co.uk

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