



**Saga HealthPlan Saver
and Saver 4 Week Wait**
Membership Handbook

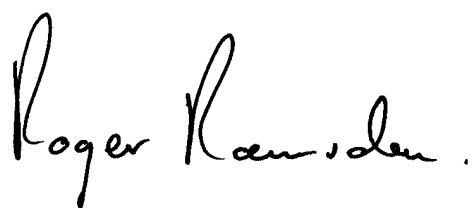
Welcome to Saga HealthPlan Saver

Thank you for choosing a Saga HealthPlan, which we have arranged to be underwritten by AXA PPP healthcare Limited. We aim to provide the highest level of care and service possible for our customers, so we have designed this policy with your needs in mind.

This booklet describes your cover in detail and should provide you with all you need to know about your policy, including how to go about making a claim. We have tried to make sure it is as straightforward and as easy to understand as possible. It is also organised into sections to help you quickly find the information you need.

Please take the time to read this booklet carefully to make sure you fully understand what you are covered for, and to ensure that your policy gives you the cover you want.

If you have any questions at all, feel free to call us on the relevant telephone number overleaf and one of our customer care advisers will be happy to help.

A handwritten signature in black ink that reads "Roger Ramsden". The signature is written in a cursive style with a period at the end.

Roger Ramsden
Chief Executive

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Contacting us

While it is important that **you** read and understand your **policy** handbook, **we** understand that it is often easier to call **us** to obtain information. So **we** have a team of Claims Personal Advisers to help **you**.

You must always call **our** Claims Personal Advisers on 0845 300 4459 when **you** need **treatment**. Please remember **you** must obtain written authorisation for any claim from **us** before starting **treatment**. If **you** do not, **we** will be unable to pay for the **treatment you** receive.

Quick reference guide for important information

Saga HealthPlan Saver and Saga HealthPlan Saver 4 are underwritten by AXA PPP healthcare, therefore any reference to '**we, us, our**' in this document means AXA PPP healthcare.

To speak to a healthcare professional

Saga Health Information Line
0800 17 40 17

Available: day or night, 365 days a year.

Our health information service. See Section 11.

To make a new claim or for help with an existing claim

Claims Personal Advisory Team
0845 300 4459

Available: Monday to Friday 8am-8pm, Saturday 9am-5pm.

Fax: 01892 503172

Please remember that **you** must obtain written authorisation for your claim from **us** before starting any **treatment**.

To discuss or to make changes to your Saga HealthPlan policy

Customer Care Team
0845 300 0867

Available: Monday to Friday 8.30am-5.30pm, Saturday 9am-1pm.

We are committed to giving customers access to **our** products. To contact **us** by Text Relay on any of the numbers listed in this handbook just prefix the number listed with **18001**.

For example, **our** Claims Personal Advisory Team can be contacted by Text Relay on **18001 0845 300 4459** and the Saga Health Information Line can be contacted on **18001 0800 17 40 17**.

Calls to all the telephone numbers above may be recorded in case of subsequent query.

1 Introduction

What is the purpose of this handbook and how to use it

This handbook sets out the terms of your cover for Saga HealthPlan Saver and Saga HealthPlan Saver 4. If **you** are unsure of which particular **policy you** have, please refer to your Membership Statement.

Prior to the end of any **policy year** Saga will write to the **policyholder** to advise on what terms the **policy** will continue, provided that the **policy you** are on is still available. This will include an 'endorsement' which contains details of any amendments that will apply to this **policy**.

This handbook and any endorsements which amend it are important documents as they detail:

- the cover **you** have (both benefits and limitations);
- how to make a claim;

- how your **policy** is administered; and
- other services provided by your **policy**.

Throughout your handbook certain words and phrases appear in **bold type** to indicate they have a special medical or legal meaning. **You** will find a glossary of these words in Section 13.

Please note:

This handbook contains information on more than one **policy** within the Saga HealthPlan range. Most of the information is relevant to all policies. However, there are instances where information is not relevant to all policies. Where this occurs, **we** have drawn your attention to which particular **policy we** are referring to as follows:

When a sentence or paragraph starts with a **policy** name and is in italics, it means that the information given relates only to the **policy** name stated.

2 Your cover

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

In return for payment of the premium **we** agree to provide cover as set out in the terms of this **policy**. Please refer to the definition of '**policy**' in the glossary for details of the documents that make up your **policy**.

Summary of the Saga HealthPlan Saver and Saga HealthPlan Saver 4 plan

The Saga HealthPlan Saver and Saga HealthPlan Saver 4 policies offer **you** cover for necessary **treatment** of new **medical conditions** that arise after **you** join. They do not cover **you** for **treatment** of **medical conditions** that existed, or **you** had symptoms of, before joining. However, in some circumstances **you** may have joined on a different basis, please refer to the 'Existing medical conditions' section for further information. There is also no cover for ongoing, recurrent and long-term conditions (also known as **chronic conditions**).

Your cover includes:

- **in-patient** and **day-patient treatment** and associated **specialists'** charges
- **out-patient surgical procedures**
- radiotherapy and chemotherapy
- one computerised tomography (CT), magnetic resonance imaging (MRI) or positron emission tomography (PET) scan received before **eligible in-patient treatment**
- CT, MRI and PET scans performed within eight months after **eligible in-patient** or **day-patient treatment**, or after an **out-patient surgical procedure**
- up to £500 of benefits for **out-patient diagnostic tests**, **out-patient consultations**, **clinical practitioner** and **complementary practitioner** charges. **Out-patient diagnostic tests** and consultations must be received before, or within eight months after, **eligible in-patient** or **day-patient treatment** or an **out-patient surgical procedure** and **clinical practitioner** and **complementary practitioner treatment** must be received within eight months after **eligible in-patient** or **day-patient treatment** or an **out-patient surgical procedure**.

Saga HealthPlan Saver 4 members:

*With a '4 Week Wait' plan, if the NHS can give **you** the hospital **treatment you** need within four weeks of the **specialist** confirming that it is needed, then **you** must use the NHS. Please see the '**Benefits table**' section for more information.*

This **policy** has a No Claim Discount scheme, which entitles **you** to a No Claim Discount provided **you** don't make a claim. Please see the 'Additional information' section for details of how your No Claim Discount is calculated.

Be aware:

Your policy will not cover you for:	Where can I find more information?
General dental procedures	Section 6
Routine pregnancy and childbirth	Section 6
Treatment of psychiatric illness	Section 6
<i>Saga HealthPlan Saver 4 members: Urgent or emergency treatment</i>	<i>Section 4</i>
Charges when treatment is received outside of the Saga Countrywide Hospital List	Section 8
Treatment that we have not first authorised in writing as eligible for payment	Section 4

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

Please note:

We will pay **eligible** fees in full when a **specialist**, **clinical practitioner**, **complementary practitioner**, or **nurse** charges up to the level within **our** published Schedule of Procedures and Fees. Please see the 'Who we pay for treatment' section of this handbook for full details.

3 Benefits table

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

Please make sure **you** call **us** on 0845 300 4459 prior to **treatment** so that **we** can confirm the extent of your cover and any limitations that may apply.

Please note: **You** must obtain written authorisation for your claim from **us** before starting any **treatment**. **You** must send the completed form to **us** for confirmation of your cover. If **you** do not **we** will be unable to pay for the **treatment you** receive. All **in-patient treatment** and **day-patient treatment** must also take place at a **hospital** listed in the **Saga Countrywide Hospital List**.

*If **you** have Saga HealthPlan Saver 4: This **policy** will cover the cost of **in-patient** or **day-patient treatment**, or a **surgical procedure** performed as **out-patient treatment**, if the NHS could not provide that **treatment** within four weeks of the **specialist** confirming that it is needed. The only exceptions to this provision are shown in the following paragraph (Immediate cover) and radiotherapy or chemotherapy performed as **day-patient treatment** or **out-patient treatment**.*

*Immediate cover: **We** will pay as per benefit 1 in the **benefits table** for the **surgical procedures** shown below, whether or not the patient could obtain **treatment** as an NHS patient within four weeks of the **specialist** confirming that it is needed.*

- varicose veins surgery
- tonsillectomy
- insertion of grommets
- removal of bunions (hallux valgus)
- removal of gall bladder – (laparoscopic cholecystectomy)
- haemorrhoidectomy
- adenoidectomy
- correction of squint
- cataract surgery.

*There is no benefit available for urgent or emergency **treatment** or if the NHS could provide the **in-patient** or **day-patient treatment** or **out-patient surgical procedure** within four weeks of the **specialist** confirming that it is needed.*

Optional excess information

Excess for each person covered by these **policies** each **year**:

Option 1 £100

Option 2 £250

Option 3 £500

Option 4 £750

Option 5 £1,000

Excesses do not apply to NHS cash benefit.

Benefits	Amount payable	For more information
In-patient and day-patient treatment		
1. Hospital charges: Including charges for accommodation, diagnostic tests , operating theatre charges, nursing care, drugs and dressings, physiotherapy, and surgical appliances used by the specialist during surgery.	No annual maximum at a hospital listed in the Saga Countrywide Hospital List	8
2. Specialists' fees (Surgeons, anaesthetists and physicians).	No annual maximum	9
3. In-patient consultations – benefit for a consultation with a second specialist arranged by the treating specialist .	No annual maximum	9
Out-patient treatment		
4. Surgical procedures.	No annual maximum	6
5. Specialist consultations. 6. Diagnostic tests. 7. Clinical practitioner charges (including physiotherapists). 8. Complementary practitioner charges	These four benefits (5, 6, 7 and 8) have a combined overall limit of £500 a year Treatment under benefits 5 and 6 must be received before, or within eight months after, eligible in-patient or day-patient treatment or an out-patient surgical procedure Treatment under benefits 7 and 8 must be received within eight months after eligible in-patient or day-patient treatment or an out-patient surgical procedure	9
9. Radiotherapy (the use of radiation to treat cancers) and chemotherapy (the use of drugs to treat cancers).	No annual maximum	7
10. (i) One computerised tomography (CT), magnetic resonance imaging (MRI) or positron emission tomography (PET) performed before eligible in-patient treatment . (ii) CT, MRI or PET scans performed within eight months after eligible in-patient or day-patient treatment , or after an out-patient surgical procedure .	Paid in full in any scanning centre listed in the Saga Countrywide Hospital List	8
Other benefits		
11. Nursing at home.	Paid in full for up to a total of 2 weeks when treatment : • is provided immediately after a period of eligible in-patient treatment • is provided by a nurse under the control of a specialist • is skilled nursing care provided at your home • is provided for at least 7 hours a day	
12. NHS cash benefit. This benefit is paid for each night you receive free treatment under the NHS and only if: (i) you are admitted for in-patient treatment before midnight (ii) the treatment you receive under the NHS would have been eligible for benefit privately under this policy . • <i>Saga HealthPlan Saver 4 members: The four weeks waiting period does not apply to NHS cash benefits. There is no requirement for private treatment to have preceded any period in an NHS intensive therapy unit or NHS intensive care unit.</i>	£100 a night, up to £2,000 a year	8
13. Saga Health Information Line. Confidential medical information.	Immediate access 24 hours a day, 365 days a year.	11

4 Arranging treatment and making a claim

How to arrange treatment and make a claim

Please remember that **you** must obtain written authorisation for your claim from **us** before **you** start any **treatment**. **You** must send your completed claim form to **us** for confirmation of cover. Otherwise **we** will be unable to pay for **treatment you** receive. All **in-patient** and **day-patient treatment** must also take place at a **hospital** listed in the **Saga Countrywide Hospital List**.

To ensure your claim proceeds smoothly, please follow these simple steps	
Step One	Your GP refers you to a specialist for private treatment .
Step Two	<p>You need to call us on 0845 300 4459 to check that treatment is eligible but please remember that cover for your claim can only be confirmed once we have received the completed claim form.</p> <p>Please help us by having the following details available:</p> <ul style="list-style-type: none"> • Specialist or group practice name • Hospital name and any admission dates • A procedure code if you are having a surgical procedure.
Step Three	<p>We will then:</p> <ul style="list-style-type: none"> • Check that we will pay the specialist's fees in full • Confirm which hospitals are covered • Send you a partially completed claim form.
Step Four	<p>Complete your section of the claim form, answering all the questions. Ensure you include the date you first became aware of the condition you are claiming for, and if you have experienced similar symptoms before, tell us when.</p> <p>Ask your GP to complete the remainder of the claim form and return it to us at the address shown on the form.</p>
Step Five	<p>Once we have received your completed claim form we will then:</p> <ul style="list-style-type: none"> • Assess the claim and send you by 1st class post written confirmation detailing whether we will cover the treatment • Remind you of any benefit restrictions that may affect your claim. <p>(Note: in most of the cases – and provided that your claim form has been completed correctly – we should be able to give you an answer within two working days.)</p>
Step Six	Send in any outstanding accounts for treatment to the Claims Personal Advisory Team.

Please send any correspondence to: Saga Claims Personal Advisory Team, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL.

Please note:

Saga HealthPlan Saver 4 members:

1. There is no cover for urgent or emergency **treatment**.
2. If a **surgical procedure** or **in-patient** or **day-patient treatment** is necessary **you** will need to establish that **treatment** is not available on the NHS within four weeks of the **specialist** confirming that it is needed (unless the **surgical procedure** is one specified in the list in your **benefits table** or **you** are receiving radiotherapy or chemotherapy as **day-patient treatment** or **out-patient treatment**).

Be aware:

When **you** ask your GP to complete the claim form they may make a charge, which **we** will not refund.

What happens if I require emergency treatment?

Saga HealthPlan Saver 4 members: This **policy** will only provide benefit for **in-patient treatment**, **day-patient treatment** and **out-patient surgical procedures** if the NHS cannot provide that **treatment** within four weeks of the **specialist** confirming that it is needed.

Be aware:

This means that conditions for which urgent or emergency **treatment** is needed are not covered by the **policy**. As **you** will appreciate, if **you** have a serious or life threatening condition which needs urgent **treatment** the NHS will treat that condition within four weeks. Your **policy** therefore will not cover it because of its urgent or emergency nature.

Saga HealthPlan Saver members: Most private hospitals are not set up to receive emergency admissions. In an emergency **you** should call for an NHS ambulance or visit the accident and emergency department at the local NHS hospital.

However, if **you** are admitted as an **in-patient** at an NHS hospital, please ask somebody to telephone **us** as **you** may be able to claim for the NHS cash benefit shown on the **benefits table**.

How are my medical bills settled?

We normally receive accounts for **treatment** directly from **specialists** or **hospitals**. However, if **you** receive an account for payment, please forward it to **us**. We can settle **eligible** bills direct with the **hospital** or **specialist**, subject to any excess. If **you** have paid the accounts, then **we** will reimburse **you**.

What must I provide when making a claim?

- 4.1 Before **we** can consider a claim **you** must ensure that:
- **you** obtain and complete any form required by **us** in order to provide **us** with the necessary information and necessary legal permissions to handle your medical information and to assess your claim. **We** will require this before starting any **treatment** in order to obtain written authorisation for your claim from **us**; and
 - **we** receive original invoices for **treatment** costs; and
 - **you** promptly give **us** all the information **we** request.

Do I need to provide any other information?

- 4.2 It may not always be possible to assess the eligibility of your claim from the claim form alone. In such situations **we** may require additional information. Where **we** request that **you** provide additional information it is your responsibility to provide any reasonable additional information to enable **us** to assess your claim.

Be aware:

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

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

What should I do if I have cover on another insurance policy?

- 4.4 **You** must tell **us** if **you** can claim any of the cost from another insurance policy. If another insurance policy is involved **we** will only pay **our** proper share.

What should I do if the benefits I am claiming for relate to an injury or medical condition caused by another person?

- 4.5 **You** must tell **us** on the claim form if **you** can claim any of the cost from anyone else. If benefits are claimed for **treatment** to **you** when the injury or **medical condition** was caused by some other person (the 'third party'), **we** will pay those benefits **you** can claim under the **policy**.

- 4.6 If another insurance policy covers those benefits then **we** will only pay **our** proper share of the benefits. However, in paying those benefits, **we** obtain both through the terms of the **policy** and by law a right to recover the amount of those benefits from the third party. In this case, the following shall apply:

- **you** must tell **us** as quickly as possible if **you** believe a third party caused the injury or **medical condition** or if **you** believe they were at fault. **We** may then write to **you** or the third party if **we** require further information; and
- **you** must include all monies paid by **us** in respect of the injuries (and interest on those monies) in your claim against the third party ('**our** outlay'); and
- **you** (or your solicitors) must keep **us** fully informed about the progress of your claim and any action against the third party or any pre-action matters; and
- **you** (or your solicitors) must keep **us** informed of the outcome of any action or settlement (providing **us** with access to the details of any such settlement);
- should **you** successfully recover any monies from the third party they should be repaid directly to **us** within 21 days of receipt on the following basis:
 - if the claim against the third party settles in full **you** must repay **our** outlay in full; or
 - if **you** recover only a percentage of your claim for damages **you** must repay the same percentage of **our** outlay to **us**; or
 - if your claim is repaid as a global settlement (where **our** outlay is not individually identified) **you** must repay **our** outlay in the same proportion as the global settlement bears to your total claim for damages against the third party.

If **you** do not repay to **us** such monies (and any interest recovered from the third party), **we** shall be entitled to recover the same from **you** and your **policy** may be cancelled in line with 12.2(d) in the Section 'Complaint and regulatory information'.

The rights and remedies in this clause are in addition and not instead of rights or remedies provided by law.

5 Existing medical conditions

Please note:

The following defined terms apply to this section:

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

Pre-existing condition – any disease, illness or injury for which:

- **you** have received medication, advice or **treatment**; or
- **you** have experienced symptoms;

whether the condition has been diagnosed or not in the three years (or five years if **you** joined this **policy** on or before 15 November 2005) before the start of your cover.

Please note: if **you** joined on or after 16 November 2005, **you** may have been able to choose to include cover for **eligible treatment** of pre-existing hypertension and **specified related conditions**. If this applies to **you** it will be shown on your Membership Statement.

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

Trouble free – when **you**:

- have not had any medical opinion from a medical practitioner including GP's or **specialists**; or
- have not taken any medication (including over the counter drugs) or followed a special diet; or
- have not had any medical **treatment**; or
- have not visited a **clinical practitioner** or **complementary practitioner**;

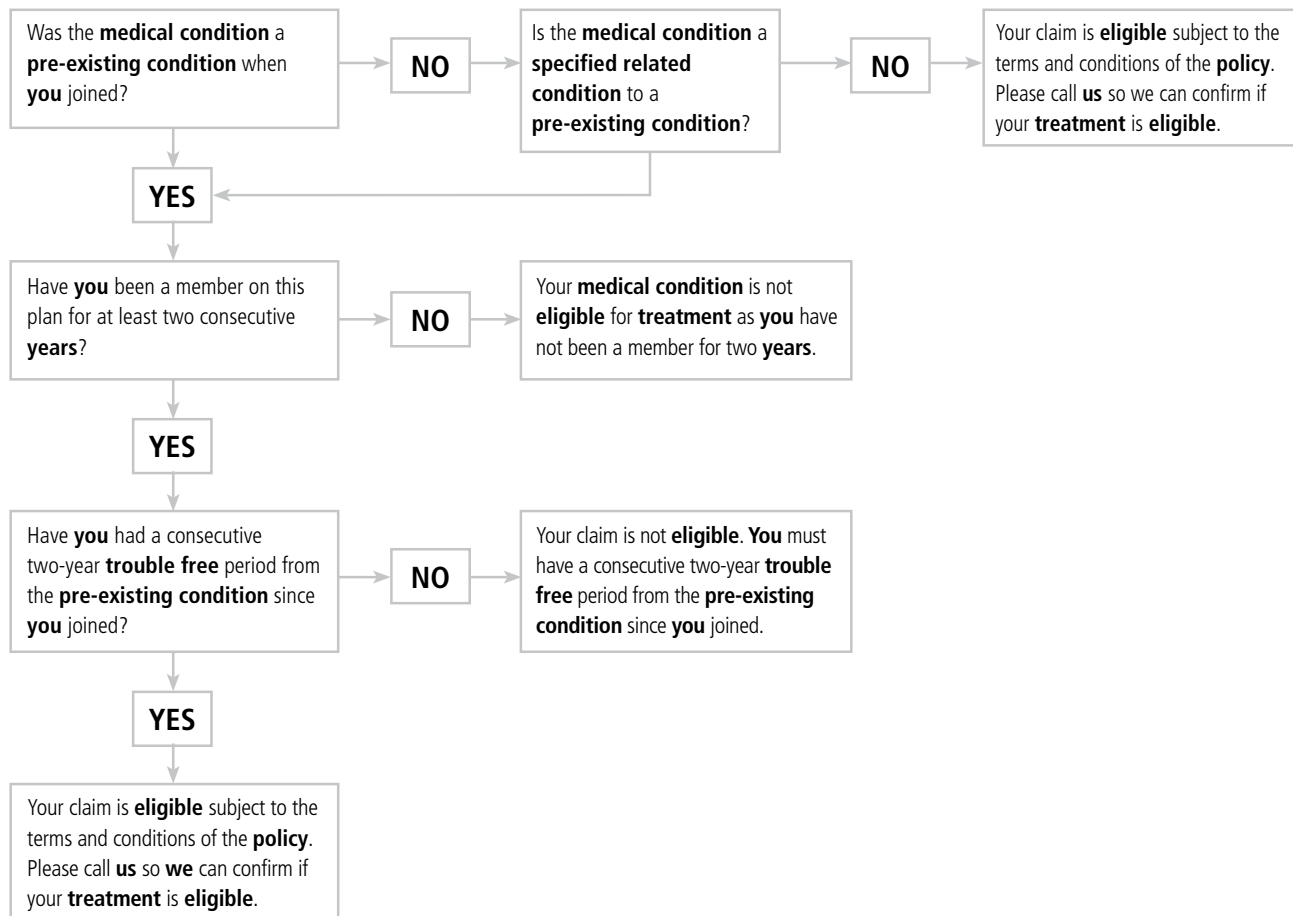
for the **medical condition**.

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

Medical insurance is designed primarily to provide cover for **treatment** of new **medical conditions** that arise after **you** join. This is the usual position. However, **you** may have joined on a different basis, particularly if **you** joined this **policy** from another insurer. Additionally, if **you** joined on or after 16 November 2005, **you** may have been able to choose to include cover for **eligible treatment** of pre-existing hypertension and **specified related conditions** to it. If these apply to **you** they will be shown on your Membership Statement.

If **you** completed a medical history declaration when **you** joined, your Membership Statement will show the **medical conditions** and **specified related conditions** for which **we** will not cover **you** for **treatment** and whether **we** can review that exclusion.

If **you** did not provide your medical history when **you** joined, the following diagram shows how your **policy** works and the process **we** go through when assessing your claim. The **policy** terms are shown on the following page.



We will provide cover for **treatment** of **medical conditions** that arise after **you** join. However, in the first two **years** of cover there is no cover for the **treatment** of **pre-existing conditions** or for **treatment** of **specified related conditions** where that **pre-existing condition** is one of those shown in the table below.

If you have the following pre-existing condition:	We will not pay for treatment of the following specified related condition/s:
Have been diagnosed with diabetes	<ul style="list-style-type: none"> • Diabetes • Ischaemic heart disease • Cataract • Diabetic retinopathy • Diabetic renal disease • Arterial disease • Stroke
Are currently undergoing treatment for raised blood pressure (hypertension)	<ul style="list-style-type: none"> • Raised blood pressure (hypertension) • Ischaemic heart disease • Stroke • Hypertensive renal failure
Are under investigation, having treatment or undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test	<ul style="list-style-type: none"> • Any disorder of the prostate

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

There are some **medical conditions** – those that continue or keep recurring – that **you** will never be able to claim for. This is because **you** will never be able to have a consecutive two-year **trouble free** period.

What happens when I want to make a claim?

If **you** completed a medical history declaration when **you** joined, your Membership Statement will show any specific exclusions that apply to your **policy**. **You** should call **us** to confirm that the **treatment you** need is **eligible**.

If **you** did not provide your medical history when **you** joined, **we** will need to assess your medical history before **we** can authorise your **treatment**. **We** may do this by asking for a claim form from your GP or **specialist**, or by asking for your GP notes.

Be aware:

Because **we** need to assess your medical history, it is possible that **we** will not be able to authorise your **treatment** straight away. There may be a short delay before **we** can confirm if your **treatment** is **eligible**.

5.1 We pay for eligible:

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

5.2 What we do not pay for:

- Treatment** of **pre-existing conditions** and **specified related conditions** where that **pre-existing condition** is diabetes, raised blood pressure (hypertension) or **you** have been undergoing monitoring as a result of Prostate Specific Antigen (PSA) test for the first two **years** after **you** join.
- If **you** completed a medical history declaration when **you** joined: **we** will not pay for **treatment** of any **medical condition** which **you** already had when **you** joined and about which **you** should have told **us**, but did not tell **us** at all or did not tell **us** everything. This includes any such **medical condition(s)** or symptoms, whether or not being treated and any previous **medical condition(s)** which recurs or which **you** should reasonably have known about even if **you** had not consulted a doctor.
- Treatment** of any other **medical condition** detailed on your Membership Statement as excluded for benefit.

6 Your cover for certain types of treatment

Will my policy cover me for preventive treatment?

No, these **policies** are designed to provide cover for necessary **treatment** of disease, illness or injury. Therefore, **we** do not pay for preventive **treatment** or for tests to establish whether a **medical condition** is present when there are no apparent symptoms.

Please note:

We do not pay for genetic tests, when those tests are undertaken to establish whether or not **you** may be genetically disposed to the development of a **medical condition**.

What other treatments are not covered?

There is no cover under this **policy** for **treatment** of psychiatric illness or other mental disorders. There are also a number of other **treatments** (listed below) that your **policy** does not cover. These include **treatments** that may be considered a matter of personal choice (such as cosmetic **treatment**) and other **treatments** that are excluded from cover to keep premiums at an affordable level (such as **out-patient** drugs and dressings).

Please note: under this **policy** specified **out-patient treatments** must be related to **eligible in-patient** or **day-patient treatment** or an **out-patient surgical procedure** in order to be **eligible** for cover. Please refer to your **benefits table** for further information.

6.1 We pay for eligible:

- (a) **Diagnostic tests** ordered by a **specialist** or GP.
- (b) Oral **surgical procedures** listed in the Schedule of Procedures and Fees. If **you** would like a copy of the Schedule of Procedures and Fees, please contact the Claims Personal Advisory Team.
- (c) Initial reconstructive surgery to restore function or appearance after an accident or following surgery for a **medical condition**, provided that:
 - **we** have covered **you** continuously under a Saga HealthPlan **policy** since before the accident or surgery happened
 - **we** agree the cost of the **treatment** in writing before it is done. (See also 6.2(i)).
- (d) **Treatment** of astigmatism where the astigmatism arises from the surgical replacement of the lens of the eye. (See also 6.2(k)).

6.2 What we do not pay for:

- (a) **Diagnostic tests** ordered by anyone other than a **specialist** or GP.
- (b) Any general dental procedure or orthodontics.
- (c) **Treatment** which is not medically necessary or which may be considered a matter of personal choice.
- (d) Any **treatment** of warts of the skin.
- (e) Vaccinations, routine preventive examinations or preventive screening.
- (f) Preventive **treatment**.
- (g) **Out-patient** drugs or dressings.
- (h) The costs of providing or fitting any external prosthesis or appliance.
- (i) Cosmetic (aesthetic) surgery or **treatment**, or any **treatment** relating to previous cosmetic or reconstructive **treatment** (see also 6.1 (c)).
- (j) The removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons (including but not limited to breast reduction).
- (k) Any other **treatment** of astigmatism or any other refractive errors (see also 6.1 (d)).
- (l) Any **treatment** to correct long or short-sightedness.
- (m) **Treatment** directed towards developmental delay in children whether physical or psychological or due to learning difficulties.
- (n) Any charges which **you** incur for social or domestic reasons (such as travel or home help costs) or for reasons which are not directly connected with **treatment**.
- (o) Any **treatment** needed as a result of nuclear contamination, biological contamination or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed. Please note, for clarity: There is cover for **treatment** required as a result of a **terrorist act** providing that the **terrorist act** does not result in nuclear, biological, or chemical contamination.
- (p) **Treatment** of any psychiatric illness.
- (q) **Treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide.
- (r) **Treatment** of, or **treatment** which arises from or is in any way connected with, alcohol abuse or drug abuse or substance abuse.
- (s) Claims on this **policy** if **you** live outside the **United Kingdom** or any **treatment** received outside the **United Kingdom**.
- (t) *Saga HealthPlan Saver 4:*
*Anything outside the terms of cover, which for clarity includes any urgent or emergency **treatment**. **We** also do not pay for **treatment** of any **medical condition** unless recommended **treatment** is not available under the NHS within four weeks of the **specialist** confirming that it is needed. This requirement shall not apply to those **surgical procedures** listed in the **benefits table** or radiotherapy or chemotherapy as **day-patient** or **out-patient treatment**.*

Will my policy cover me for new or experimental treatments?

Your **policy** only covers **you** for established medical **treatments**.

Be aware:

There is no cover for any **treatment** or procedure that has not been established as being effective or which is experimental.

6.3 We pay for eligible:

- (a) **Surgical procedures** listed in a technical document, called the Schedule of Procedures and Fees, which **we** make available to **specialists** and which lists the **surgical procedures we** pay benefits for. **We** will pay for **treatment** not listed if, before the **treatment** begins, it is established that the **treatment** is recognised as appropriate by an authoritative medical body and **we** have agreed with the **specialist** what the fees will be. If **you** would like a copy of the Schedule of Procedures and Fees please contact the Claims Personal Advisory Team.
- (b) Reasonable costs incurred for a live donor to donate an organ or tissue provided that:
 - the operations to both the donor and the recipient are carried out simultaneously; and either
 - both the donor and the recipient are immediate relatives (ie parent, child or sibling) and either the donor or the recipient is covered by the **policy**; or
 - both the donor and the recipient are members of a private medical insurance policy underwritten by AXA PPP healthcare at the time both the operations are carried out and both have been members since before the recipient developed the **medical condition** requiring the transplant (see also 6.4(c)).

6.4 What we do not pay for:

- (a) The use of a drug which has not been established as being effective or which is experimental. This means they must be licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and be used within the terms of that licence.
- (b) **Treatment** which has not been established as being effective or which is experimental. For established **treatment**, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced in published medical journals and/or approved by the National Institute for Health and Clinical Excellence for specific purposes to be considered proven safe and effective therapies.
- (c) The cost of collecting donor organs or tissue or for any related administration costs (such as, but not limited to, the cost of a donor search).

Childbirth, pregnancy and sexual health

Our policies are designed to provide cover for necessary and active **treatment** of a **medical condition** (which **we** define as a disease, illness or injury). This means for pregnancy and childbirth that **we** will only pay for **eligible** additional **treatment** made necessary by a **medical condition** that is experienced during that pregnancy and/or childbirth. Your **policy** is not intended to provide cover for preventive **treatment**, monitoring or screening. **We** do not pay for the normal interventions required during pregnancy or childbirth as they are not **treatments** of a **medical condition**.

Be aware:

As the extent of cover is limited in pregnancy and childbirth **we** strongly advise **you** to call the Claims Personal Advisory Team so **we** can confirm the extent of the cover **we** will provide before **you** undertake any **treatment**.

6.5 We pay for eligible:

- (a) Additional costs incurred for the **treatment** of **medical conditions** when they occur during that pregnancy or childbirth. As an illustration **we** would consider **treatment** of the following:
 - ectopic pregnancy (where the foetus is growing outside the womb)
 - hydatidiform mole (abnormal cell growth in the womb)
 - retained placenta (afterbirth retained in the womb)
 - placenta praevia
 - eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
 - diabetes (if **you** have exclusions because of your past medical history which relate to diabetes, then **you** will not be covered for any **treatment** for diabetes during pregnancy)
 - post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
 - miscarriage requiring immediate surgical **treatment**
 - failure to progress in labour.

6.6 What we do not pay for:

- (a) Any costs related to pregnancy or childbirth except the additional costs incurred for **eligible treatment** of a **medical condition**.
- (b) Investigations into and **treatment** of infertility, contraception, assisted reproduction, sterilisation (or its reversal) or any consequence of any of them or of any **treatment** for them.
- (c) **Treatment** of impotence or any consequence of it.
- (d) Gender re-assignment operations or any other surgical or medical **treatment** including psychotherapy or similar services which arise from, or are directly or indirectly associated with, gender re-assignment.

7 Recurrent, continuing and long-term treatment

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

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

We define a **chronic condition** in the glossary as:

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

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

Please note:

Your **policy** will cover **you** for the following phases of **treatment** for a **chronic condition**:

- the initial investigations to establish a diagnosis
- **treatment** for a period of a few months following diagnosis to allow the **specialist** to start **treatment**
- the **in-patient treatment** of acute exacerbations or complications (flare-ups) in order to quickly return the **chronic condition** to its controlled state.

What happens if I require recurrent or long-term treatment?

In the unfortunate event that the **treatment** **you** are receiving becomes recurrent, continuing or long-term, the costs for **treatment** of that **chronic condition** (including long-term monitoring, consultations, checkups and examinations) will not be covered under your **policy**. **We** will write to let **you** know if this is the case.

There are certain conditions that are likely to require ongoing **treatment** - such as Crohn's disease (inflammatory bowel disease) - which require management of recurrent episodes where the condition's symptoms deteriorate. Because of the ongoing nature of these conditions **we** will write to tell **you** when the benefit for that condition will stop.

Where can I find out more about cover for chronic conditions?

We publish a leaflet which explains how **we** deal with payment for **treatment** of **chronic conditions**. This is available on the Saga website (saga.co.uk/health-insurance) and can also be obtained from **us**. **You** will also find further explanation of how **we** deal with payment for **cancer treatments** later in this Section.

7.1 We pay for eligible:

- (a) **Treatment** of an **acute condition** and the short-term **in-patient treatment** intended to stabilise and bring under control a **chronic condition**.
- (b) Kidney dialysis for up to six weeks during preparation for kidney transplant.
- (c) **In-patient** rehabilitation of up to 28 days when it is an integral part of **treatment**; and:
 - it is carried out by a **specialist** in rehabilitation;
 - it is carried out in a recognised rehabilitation **hospital** or unit which is either listed in the **Saga Countrywide Hospital List** or **we** have written to confirming it is recognised by **us**;
 - the costs have been agreed by **us** before the rehabilitation begins.

We will extend **in-patient** rehabilitation to a maximum of 180 days in cases of severe central nervous system damage caused by an external trauma.

7.2 What we do not pay for:

- (a) Ongoing, recurrent or long-term **treatment** of any **chronic condition**.
- (b) The monitoring of a **medical condition**.
- (c) Any **treatment** which only offers temporary relief of symptoms rather than dealing with the underlying **medical condition**.
- (d) Routine follow-up consultations.
- (e) Regular or long-term kidney dialysis in the case of chronic kidney failure.
- (f) **Treatment** of any **medical condition** which arises in any way from HIV infection.
- (g) Any hormone replacement therapy (HRT).

Your cover for cancer treatment

You are covered for **treatment** of a new **cancer** which arises after **you** join and for any recurrence of this **cancer**. If **you** have exclusions because of your past medical history which relate to a **cancer**, then **you** will not be covered for any recurrence of that **cancer**. Please refer to the section 'Existing medical conditions' for further information on your cover for pre-existing **medical conditions**. Your **policy** covers the investigation and **treatment** intended to affect the growth of the **cancer** by shrinking it, stabilising it or slowing the spread of disease. This includes surgery, radiotherapy or chemotherapy, alone or in combination.

The **policy** does not cover the long-term management of **cancer** other than shown on the table opposite and there is no cover for **treatment** given solely to relieve symptoms.

If **you** have *Saga HealthPlan Saver 4* please note that this cover is subject to the restrictions on this **policy** on:

- any urgent or emergency **treatment**
- **treatment** that is available under the NHS within four weeks of the **specialist** confirming that it is needed.

NHS or private?

Whilst **you** are covered for **eligible cancer treatment** on this **policy you** may decide that **you** want to receive **treatment** on the NHS. Should **you** choose to receive your **treatment** as an NHS patient **you** will be **eligible** to receive the NHS hospital cash benefit shown in the **benefits table**, when **you** receive **eligible in-patient treatment**. The following table is a summary of the cover provided for **cancer** under this **policy** and should be read alongside the rest of the handbook, including the **benefits table**.

	Cover	
Where am I covered for treatment?	✓	Treatment of cancer at any hospital listed in the Saga Countrywide Hospital List .
	✗	Charges made for the treatment of cancer at any hospital not listed in the Saga Countrywide Hospital List .
	✓	Home nursing received at home in the circumstances shown in the benefits table .
	✗	Treatment received at a hospice.
What cover do I have for diagnostic procedures?	✓	Consultations with a specialist and diagnostic tests ordered by a specialist or GP. Out-patient consultations and diagnostic tests are subject to any out-patient benefit limits and must be received before, or within eight months after, in-patient or day-patient treatment or an out-patient surgical procedure covered by this policy .
	✓	Surgical procedures as shown below.
	✓	One CT, MRI or PET scan which is performed before eligible in-patient treatment .
	✓	CT, MRI and PET scans performed within eight months after eligible in-patient or day-patient treatment , or after an out-patient surgical procedure .
	✗	Genetic screening required to establish a genetic pre-disposition to certain forms of cancer .
What cover do I have for surgical treatment?	✓	Surgical procedures for the treatment or diagnosis of cancer , as shown on the opposite page, when that treatment has been established as being effective.
	<i>Saga HealthPlan Saver 4</i>	<i>At the time of going to print the NHS was commonly providing treatment of cancer within four weeks and therefore it is unlikely that there will be cover on this policy for such surgical treatment.</i>
	✗	Experimental or unproven surgery. Please refer to Section 6 for further information.
Am I covered for preventive treatment?	✗	Preventive treatment , for example: <ul style="list-style-type: none"> • Screening undertaken as a preventive measure where there are no symptoms of cancer. For example, if you receive genetic screening, the result of which shows a genetic predisposition to breast cancer, you would not be covered for the screening or a prophylactic mastectomy to prevent the development of breast cancer in the future. • Vaccines to prevent the development or recurrence of cancer, for example vaccinations for the prevention of cervical cancer.
What cover do I have for drug therapy?	✓	Drug treatment of cancer (such as chemotherapy drugs, hormone therapies and biological therapies) where the drug has been licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and is used within the terms of that licence.
	✓	There are some drug treatments for cancer that are typically given for prolonged periods of time. Such prolonged treatment normally falls outside benefit. However in the case of cancer we make an exception (subject to the limits detailed below) for chemotherapy drugs and biological therapies such as trastuzumab (Herceptin) and bevacizumab (Avastin). The cover provided by this policy for prolonged cancer drug treatment is payable once per course of cancer treatment . By 'course of cancer treatment ' we mean from diagnosis of a primary or secondary cancer (whichever occurs first) through to the final surgery, radiotherapy or chemotherapy for that primary or secondary cancer (whichever occurs last). These drug treatments will be covered for up to: <ul style="list-style-type: none"> • one year of such treatment; or • the period of the drug licence whichever is the shorter. The time limit starts from when you first started receiving that drug, however it may have been funded. In any event, these drugs will only be eligible for benefit when they are used within the terms of their licence and in circumstances where they are proven to be effective treatments . Please note: Changes in drug licensing mean that cancer drug treatment covered under this policy will change from time to time. For further information on licensed cancer treatment please contact the Claims Personal Advisory Team.
	✗	Except for the cover provided for chemotherapy drugs and biological therapies previously described there is no cover for drug treatment given to prevent a recurrence of cancer , for the maintenance of remission or where its use is continuing without a clear end date. Such ongoing treatments are not eligible although, if they are given by injection, for example goserelin (Zoladex), we would pay for up to three months to allow the treatment to be established.
	✗	Out-patient drugs and drugs prescribed by your GP. For example, hormone therapy tablets (such as Tamoxifen) are out-patient drugs and therefore are not covered by our policies.
	✓	Radiotherapy, including when used to relieve pain.
Am I covered for terminal care?	✗	There is no cover for terminal care, wherever carried out.
Am I covered for monitoring?	✗	Monitoring of cancer usually takes place during out-patient consultations. These must be received before, or within eight months after, eligible in-patient or day-patient treatment or an out-patient surgical procedure . Therefore you do not have cover for the monitoring of cancer .
Am I covered for bone marrow or stem cell treatment?	✓	Stem cell treatment and bone marrow treatment , including the reasonable costs incurred for a live donor to donate bone marrow or stem cells as shown in Section 6.
	✗	Any related administration costs (such as, but not limited to, transport costs and the cost of a donor search).

8 Where you are covered for treatment

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

The **Saga Countrywide Hospital List** lists the **hospitals** and **day-patient units** in the **United Kingdom** for which **we** provide cover.

Please note:

It may be necessary from time to time for **us** to suspend the use of a **hospital, day-patient unit** or **scanning centre** listed in the **Saga Countrywide Hospital List** so as to protect the interests of all **our** customers.

You need to call **us** before receiving any **treatment**. This will allow **us** to check **our** database and confirm whether the **hospital you** have been referred to is **eligible** for benefit.

If it is medically necessary for **you** to use a hospital, day-patient unit or scanning centre not listed in the **Saga Countrywide Hospital List** and **we** have specifically agreed to this in writing before the **treatment** begins, then **we** will pay those hospital charges.

What happens if I choose to have treatment at a hospital which is not in the Saga Countrywide Hospital List?

If **you** have **in-patient treatment, day-patient treatment** or computerised tomography (CT), magnetic resonance imaging (MRI) scans and positron emission tomography (PET) in any hospital which **we** do not list in the **Saga Countrywide Hospital List** then **you** will be entirely responsible for paying the hospital bills.

If **you** have **eligible in-patient treatment** as an NHS patient incurring no charges at all, then **we** will pay any NHS cash benefit shown as benefit 12 in the **benefits table**.

Which scanning centres and out-patient facility charges are covered?

Your **policy** includes cover for computerised tomography (CT), magnetic resonance imaging (MRI) scans and positron emission tomography (PET). If **you** require CT, MRI or PET **we** will make full payment, or set the charges against any excess **you** may have, if **you** use a **scanning centre** in the **Saga Countrywide Hospital List**.

We will pay for **eligible** charges made by a provider **we** have an agreement with for the use of their facilities on an **out-patient treatment** basis (which may include charges for the use of drugs).

8.1 We pay for eligible:

- (a) *Saga HealthPlan Saver:*
Charges made by, or incurred in, a **hospital** for ITU (Intensive Therapy Unit, sometimes called Intensive Care Unit) **treatment** only when ITU **treatment** immediately follows **eligible private treatment** and **you** or your next of kin have asked for the ITU **treatment** to be received privately. (See also Section 4 for emergency treatment).
- (b) NHS cash benefit, as shown on the **benefits table**, for each night **you** receive free **treatment** in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.

8.2 What we do not pay for:

- (a) Any charges from health spas, nature cure clinics or any similar place, even if it is registered as a hospital.
- (b) Special nursing in hospital unless **we** have agreed beforehand that it is necessary and appropriate.
- (c) Any charges made by, or incurred in, an NHS hospital for ITU **treatment**, except as allowed for by 8.1(b).

9 Who we pay for treatment

Your **policy** can provide benefit for **eligible treatment** provided by **specialists, clinical practitioners, complementary practitioners** and **nurses**, subject to any **out-patient** limits.

How do I find out whether the person I am seeing for treatment is recognised?

You need to call **us** before receiving any **treatment**. This will allow **us** to check **our** database and confirm whether the person **you** have been referred to is **eligible** for benefit.

What services provided by specialists, clinical practitioners and complementary practitioners are eligible for benefit?

We will pay for charges for treatment from:	If you are referred by your GP	If you are referred by a specialist	If you are referred by your dentist
Specialists*	✓	✓	✓
Clinical practitioners	✗	✓	✗
Complementary practitioners	✗	✓	✗
Physiotherapists	✓	✓	✗

*Includes consultations, **diagnostic tests, treatment in hospital** and **surgical procedures**.

Will treatment charges be met in full?

We publish a document called the 'Schedule of Procedures and Fees' which sets out what **we** will pay **specialists, clinical practitioners, complementary practitioners** and **nurses**, for the services they provide to **our** customers. **We** will pay **eligible** fees in full when a **specialist, clinical practitioner, complementary practitioner** or **nurse** charges up to the level shown within the Schedule of Procedures and Fees. If **you** would like a copy of the Schedule of Procedures and Fees, please contact the Claims Personal Advisory Team.

We strongly advise that **you** call **us** before **you** receive **treatment** to confirm whether **we** will pay the **treatment** charges in full for the person **you** are planning to see. If **we** will not pay the fee in full **we** will tell **you** how much **we** will pay towards the cost of your **treatment**, from the Schedule of Procedures and Fees. **We** have identified **specialists, clinical practitioners, complementary practitioners** and **nurses** whose fees **we** pay in full and these make up the majority of all **specialists** and practitioners.

What if an anaesthetist becomes involved in my treatment?

Before receiving surgical **treatment** it is advisable to establish which anaesthetist your **specialist** intends to use. This will mean **we** can tell **you** if that anaesthetist is one who **we** pay in full or, if this is not the case, what fee **we** will pay (as set out in the Schedule of Procedures and Fees). However, if **you** don't know when **you** call **us** which anaesthetist your **specialist** intends to use, **we** will make every effort to notify **you** whether they commonly work with an anaesthetist who **we** do not pay in full.

9.1 We pay for eligible:

- (a) **Treatment** charges made by a **nurse** for nursing at home benefit detailed in the **benefits table**.
- (b) **Treatment** charges made at the level set out in **our** Schedule of Procedures and Fees or at the amount charged if lower than that level.

9.2 We do not pay for:

- (a) Charges made by a **specialist** or **complementary practitioner** when **you** have been referred to them by a member of your family, or if that **specialist** or **complementary practitioner** is a member of your family.
- (b) **Treatment** charges made when they are above the level set out in **our** Schedule of Procedures and Fees.
- (c) **Treatment** charges made by a **specialist, clinical practitioner, complementary practitioner** or **nurse** who **we** have identified to **you** as someone whose fees **we** will pay in full if, without **our** prior agreement, they charge significantly more than their usual amount for **treatment**.
- (d) Charges for general chiropody or foot care even if this is carried out by a surgical podiatrist.
- (e) Any charges made for written reports or any administrative costs.

10 Additional information

When can I add other members or change my cover?

You can apply to add a **family member** to your **policy** at any time. Also, **you** may be able to change your cover at your renewal. Call Saga on 0845 300 0867 to discuss the options open to **you** and we will send **you** any relevant forms to complete. **You** must keep Saga fully informed of any changes which take place between sending in any form and receiving written confirmation that the change has been made.

Can I add my new baby to my policy?

You can apply to add newborn babies (who are born to the **policyholder** or the **policyholder's** partner) to the **policy** from their date of birth and they will be covered until your next renewal at no extra premium. This can normally be done without filling out details of their medical history provided **you** add them within three months of their date of birth.

In addition to this, as long as the mother has been covered for at least ten months before the birth and **you** add your child within these first three months, then **we** will not apply the exclusion for medical conditions they had prior to joining (as detailed in Section 5) or require the child to be medically underwritten. However, **we** will require details of the baby's medical history if the baby has been adopted or was born as the result of any method of assisted conception. In such circumstances **we** reserve the right to apply particular restrictions to the cover **we** will offer and **we** will notify **you** of those terms as soon as reasonably possible. This may limit your baby's cover for existing **medical conditions**. This would mean that your baby will not be covered for **treatment** carried out for medical conditions which existed prior to joining, such as **treatment** in a Special Care Baby Unit and **you** will be liable for these costs.

Can I cancel my policy?

You have a 14 day cooling off period when **you** join and at each renewal. Please see Section 12.1(g) 'Your rights and responsibilities'.

How can I pay my premium?

At the start of each **policy year** **we** will calculate your new premium and let **you** know how much it is. **We** offer a choice of monthly or annual premiums which can be paid by Direct Debit mandate. In addition, **we** offer a choice of annual premiums which can be paid by cheque, debit or credit card. **We** offer a discount if **you** pay annual premiums.

If **you** pay by Direct Debit **we** will collect the first premium when your **policy** starts and subsequent premiums when they fall due.

Be aware:

Important - **you** must pay your premium when it is due. If **you** do not **we** will cancel your **policy** and will not pay for any **treatment** or benefit entitlement arising after that date.

Why do you make changes to my premium?

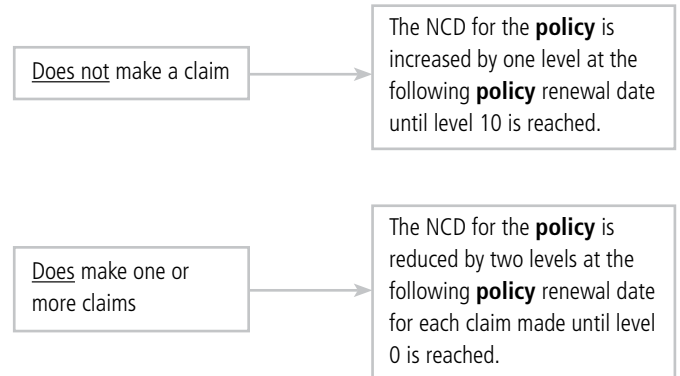
We make every effort to maintain premiums at as low a level as possible, without compromising the range and quality of the cover provided. **We** review premiums each **year** to take account of a range of statistical factors. Typically the cost of premiums has increased at a level higher than the Retail Price Index (RPI). **You** will receive reasonable notice of any changes in premium.

Your premium will also include the amount of any insurance premium tax or other taxes or levies which are payable by law in respect of your **policy**.

Your premium may also increase as a result of an increase in age.

How does the No Claim Discount scale operate?

This **policy** has a No Claim Discount (NCD) and your current NCD level is shown on your Membership Statement, this means that in any NCD year where a person or persons covered on the **policy**:



Level	Base	1	2	3	4	5	6	7	8	9	10
% Discount off basic premium rate	0	10	20	25	30	35	40	45	50	55	60

What is a claim?

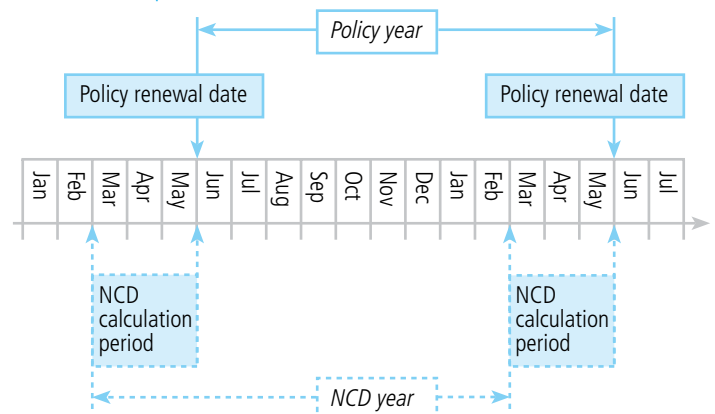
- For the purposes of the NCD a claim is any amount of money **we** pay for providing **treatment** for one **medical condition**, no matter how small but does not include claims paid for NHS cash benefits.
- The claim is recorded based on the date it is paid by **us**, rather than the date the **treatment** is received.
- We** will treat separate accounts for the same **medical condition** when they are paid within 180 days of one another as one single claim.

When do you calculate the NCD?

Your NCD level is calculated up to 3 months prior to your **policy** renewal date. This means that a claim paid in the NCD calculation period may not impact on your NCD until the following **year's** renewal.

The following diagram shows how the NCD calculation period works for a customer whose **policy** renews in June. Please refer to your Membership Statement for confirmation of when your **policy** renews.

Illustrative example



Should I pay for treatment myself to maintain my NCD level?

Before asking **us** to pay a small amount of money **you** should consider the effect this may have on the NCD for the following **year**. It may be appropriate for **you** to meet the cost of the **treatment** in order to preserve the NCD, for example if it turns out that no further **treatment** is going to be needed. However, your first consideration should always be ensuring that you receive the **treatment you** need.

At renewal, if **we** have paid claim(s) during the previous NCD year, **you** may choose to reimburse **us** the value of the claim(s). If you do this within 30 days of the **policy** renewal date **we** will recalculate your premium so **you** continue to benefit from the NCD.

Can I protect my NCD?

We may offer this option on the **policy** for an additional premium. If so, this will be shown on your Membership Statement at renewal and **you** must accept this offer within 30 days of the renewal date.

If **you** accept this offer, it currently operates in this way for NCD protection:

- 1) If **we** have not paid a claim during the previous NCD year, **we** will work out your renewal premium using the discount for the next level up from your current discount. The maximum discount is 60%. **You** will retain your No Claim Discount protection.
- 2) If **we** have paid one claim during the previous NCD year, **you** retain your current No Claim Discount level. **We** will work out your renewal premium using this same level (please note, as your premium is based on a number of factors, your premium will still increase). Your No Claim Discount protection will be removed.
- 3) For each additional claim paid during the previous NCD year, **you** will move two levels back from your current level. **You** will never pay more than the basic premium rate, no matter how many claims **we** pay.

How can an excess help to reduce my premium?

Choosing an excess on your **policy** may help to reduce your premiums. If **you** would like to find out how to add an excess or change your existing excess level please call the Saga Customer Care Team on 0845 300 0867.

I have an excess on my policy - how does this work?

If **you** have an excess on your **policy**, this is how it is applied:

- The excess (that is, the amount of money **you** have to pay towards the cost of **eligible treatment**) applies to every person covered by the **policy** in each **policy year**.
- **We** will not pay any claim or part of a claim which is subject to an excess. In this case **we** will only pay the balance of the claim after **we** have deducted the excess amount.
- The excess is deducted from any **eligible treatment** costs **you** incur.
- The excess is a single deduction that is made regardless of the number of individual **medical conditions** claimed for in that **policy year**. Should **treatment** continue beyond your **policy's** renewal date then **we** will apply the excess once against the costs incurred before this date, and again against the costs incurred on or after the renewal date. **We** will do this

irrespective of whether the costs relate to **treatment** for the same **medical condition**.

- If the first claim relates to a benefit with a monetary limit, then **we** will reduce the monetary limit by the total cost incurred before **we** apply the excess. If **you** have a high excess then **you** may find that, within a reasonable period, **you** will reach or exceed the limit of those benefits that have monetary limits.
- **We** will not apply the excess against medical costs for **treatment** that your **policy** does not cover.

Here are two examples of how the excess operates (with a £100 excess)

These policies have a benefit limit of £500 (for each person each **year**) for **out-patient** consultations, **diagnostic tests**, **clinical practitioner** charges and **complementary practitioner** charges.

Example 1	
One	You develop a medical problem and require £350 of eligible diagnostic tests – your first claim for that policy year .
Two	The £100 excess charge is applied.
Three	We pay £250 towards the £350 cost of out-patient treatment , while you pay the £100 excess.
Four	This £350 total claim reduces your £500 benefit limit for out-patient consultations, diagnostic tests , clinical practitioner charges and complementary practitioner charges to £150.
Then....	Later in the same policy year , you suffer a different medical condition , incurring costs of £200 for eligible out-patient consultations and diagnostic tests – £50 more than the policy's remaining £150 benefit limit.
So...	We pay £150 towards the cost of treatment , and you pay the £50 shortfall.

If the first claim relates to a benefit with a monetary limit, then **we** will reduce the monetary limit by the total cost incurred before **we** apply the excess. Example 2 demonstrates this.

Example 2	
One	You require £650 of eligible diagnostic tests but the policy limit is £500.
Two	So, we pay £500 for the treatment – less the £100 excess – giving a total of £400.
Three	You pay the remaining £150 not covered by the policy plus the £100 excess making a total of £250.
So...	Leaving no further benefit for out-patient consultations, diagnostic tests , clinical practitioner charges and complementary practitioner charges for the rest of the policy year .

11 Saga Health Information Line

Through the Saga Health Information Line you have access to a qualified and experienced team of healthcare professionals 24 hours a day, 365 days a year.

Whether you are calling because you have late night worries about a child's health, or you have some questions you forgot to ask your GP, it's likely that the Saga Health Information Line will be able to provide the help you need.

The team of nurses, pharmacists, counsellors and midwives is on hand to give you the benefit of their expertise. They can answer your questions and give you all the latest information on specific illnesses, treatments and medications as well as details of local and national organisations. They can also send you free fact sheets and leaflets on a wide range of medical issues, conditions and treatments, and will happily phone you back afterwards to discuss any further questions you may have from what you have read.

Saga Health Information Line - 0800 17 40 17

Saga Health Information Line is available to you any time - day or night, 365 days a year.

If calling from outside the UK please dial +44 800 17 40 17 - international call rates apply.

Please remember to have your Membership number to hand before you call.

Please note:

The Saga Health Information Line does not diagnose or prescribe and is not designed to take the place of your GP. However, it can provide you with valuable information to help put your mind at rest. As the Saga Health Information Line is a confidential service, any information you discuss is not shared with our Claims Personal Advisory Team. If you wish to authorise treatment, enquire about a claim or have a membership query, our Claims Personal Advisory Team will be happy to help you.

12 Complaint and regulatory information

Our customer service commitment to you

Saga aims to provide **you** with high levels of service at all times. However, there may be times when **you** feel that service has fallen below the standard **you** expect. If this is the case and **you** want to complain, Saga will do its best to try to resolve the situation.

Whether **you** are phoning or writing, please remember to quote your name, address and **policy** number as it will help your enquiry or complaint to be dealt with quickly.

What should I do if I have a reason to complain?

[For queries and complaints not related to a claim](#)

Step one

If **you** have a query or complaint about private medical insurance that is not regarding a claim, please contact Saga's Customer Care Team on 0845 300 0867 and they will try to resolve your complaint.

Step two

If this does not resolve your complaint please contact:
The Customer Relations Department, Saga Services Limited, Middelburg Square, Folkestone, Kent CT20 1AZ.
Alternatively call 01303 771160, fax 01303 771347
or e-mail services.customer-relations@saga.co.uk.

Step three

If **you** are still dissatisfied, **you** should write to:
Director of Customer Service, Middelburg Square, Folkestone, Kent CT20 1AZ.

Step four

If **you** are not happy with Saga's final response, **you** can ask the Financial Ombudsman Service to review your case.

[For queries and complaints related to a claim](#)

Step one

If **you** think things have gone wrong for **you** regarding a claim and **you** are unhappy with **us**, please contact the Saga Claims Personal Advisory Team in the first instance on 0845 300 4459 and they will try to resolve your complaint.

Step two

If **you** are unhappy with their response, then **we** invite **you** to contact **us**, preferably in writing, to:
Customer Relations Executive, AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL. Alternatively call 01892 503110.

We will acknowledge your complaint upon receipt, investigate it and respond to **you** within five working days of receiving your letter (**we** will, of course, keep **you** informed if there is an unavoidable delay).

Step three

If **you** are dissatisfied with this response then **we** invite **you** to write, detailing why **you** feel **our** decision is incorrect in relation to the terms and benefits of your **policy**, to:
The Operations Director, AXA PPP healthcare, PPP House, Vale Road, Tunbridge Wells, Kent TN1 1BJ

Again **we** will acknowledge your letter upon receipt. The Operations Director will then - on behalf of **our** Chief Executive - review your complaint and respond to **you** within 20 working days of receiving your letter (**we** will, of course, keep **you** informed if there is an unavoidable delay).

Step four

The Financial Ombudsman Service will review your complaint if **you** remain dissatisfied after **we** have issued **our** final decision from the Operations Director. The address **you** need to write to is:
Financial Ombudsman Service, South Quay Plaza, 183 Marsh Wall, London E14 9SR.
Telephone: 0300 123 9 123
e-mail: complaint.info@financial-ombudsman.org.uk
Website: www.financial-ombudsman.org.uk

The Ombudsman will review complaints about:

- the way in which your **policy** was sold to **you**
- the administration of your membership
- the handling of any claims

Please note that the Ombudsman will not normally investigate complaints concerning an insurer's legitimate exercise of commercial judgement.

The Ombudsman will also not usually be able to review a complaint where:

- **We** gave a final decision over six months ago
- Your case already involves (or has involved) legal action.

None of these procedures affect your legal rights.

What regulatory protection do I have?

[The Financial Services Authority](#)

AXA PPP healthcare and Saga Services Limited are authorised and regulated by the Financial Services Authority (FSA). The FSA was established by government to provide a single statutory regulator for financial services. The FSA is committed to securing the appropriate degree of protection for consumers and promoting public understanding of the financial system. The FSA has set out rules which regulate the sale and administration of general insurance which **we** must follow when **we** deal with **you**. AXA PPP healthcare's FSA register number is 202947.

This information can be checked by visiting the FSA register which is on their website: www.fsa.gov.uk/register/home.do or by contacting the FSA on 0300 500 5000.

[The Financial Services Compensation Scheme](#)

AXA PPP healthcare is also a participant in the Financial Services Compensation Scheme established under the Financial Services and Markets Act 2000. The scheme is administered by the Financial Services Compensation Scheme Limited (FSCS), a body established by the FSA. The scheme is governed by FSA Rules and may act if it decides that an insurance company is in such serious financial difficulties that it may not be able to honour its contracts of insurance. The scheme may assist by providing financial assistance to the insurer concerned, by transferring policies to another insurer, or by paying compensation to eligible policyholders. Further information about the operation of the scheme is available on the FSCS website: www.fscs.org.uk

What we do with your personal data

Please ensure that **you** show the following information to others covered under your **policy**, or make them aware of its contents.

Much of the personal information Saga and the underwriter of your **policy**, AXA PPP healthcare Limited, hold about **you** is obtained when **you** apply for a Saga Private Medical Insurance **policy**, and when a claim is made. This may include medical information **we** obtain from medical practitioners and other health consultants.

Saga will keep your information securely and use it to provide the highest standard of service in the administration of this **policy** and other products that **you** hold with Saga. Saga will also use it for underwriting and pricing purposes and, in certain circumstances, claims mediation and market research, and to maintain management information for business analysis.

AXA PPP healthcare will handle your information on a confidential basis and use it to process claims, for underwriting and pricing purposes and to maintain management information for business analysis. It will disclose this information to Saga or service providers as appropriate for these purposes and to help with the administration of your **policy**. Where it does so, it will put in place safeguards such as contract terms to protect your confidentiality.

In the event of a claim, AXA PPP healthcare may have to give some information about **you** and/or any named **family member** to those involved in your/their treatment or care, but this will be done confidentially. With your/their consent it may also disclose information to a representative **you/they** have chosen.

Correspondence about any claim will be addressed to the **policyholder**. If a claim is made by a **family member**, AXA PPP healthcare will keep any personal information in this correspondence to the minimum it needs in order to process the claim. It may use or give data to others outside Saga or AXA PPP healthcare for research, statistical purposes or to improve their services, but it will remove your name and address from this data first.

Saga and AXA PPP healthcare's purposes for processing information and the people and organisations to whom it may be given, are each listed in the Register of Data Controllers.

The Register is maintained by the Information Commissioner at Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF (telephone number 01625 545 745 - facsimile number 01625 524 510). **You** are free to inspect this or obtain a copy of the requisite entry from the Information Commissioner.

You should be aware that Saga and AXA PPP healthcare do not supply any information about **you** to anyone unless **we** believe it is lawful to do so, or when **we** are requested to do so by **you** and have your consent in advance. However, **we** may, at **our** discretion, appoint a third party to service the **policy**, including another company based outside the European Economic Area.

Marketing policy

Saga may share your personal information, and your medical data, with other Saga Group companies. By providing Saga and AXA PPP healthcare with your personal data and contact details, **you** consent to Saga Group using it for administrative purposes and to the Saga and Acromas groups of companies and their partners contacting **you** by post, telephone, e-mail, SMS or other electronic means, to inform **you** about any products and services which it considers may be of interest to **you**. Saga will do this unless **you** contact them or **you** make use of the regular opportunities that they provide **you** with, to confirm which channels and products **you** do and do not wish to use or hear about, or unless **you** tell Saga **you** prefer not to receive direct marketing.

Obtaining a copy of the information we hold about you

You may request a copy of the information Saga and AXA PPP healthcare hold about **you** and have any inaccurate data corrected. If **you** wish to access your personal information, please write to the Data Protection Officer at Saga Group and/or AXA PPP healthcare. **We** are entitled to charge a fee, currently £10, which is payable for accessing this information. When information has been supplied by a medical practitioner, **you** should be aware that their consent is needed before this can be supplied to **you**.

Crime prevention and detection and legal requirements

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

Keeping information

Saga and AXA PPP healthcare will continue to hold information about the **policy** and any claim made under the **policy** for some time after it has ended. **We** will then dispose of your information in a responsible way.

Future underwriter changes

Your Saga Private Medical Insurance **policy** is currently provided and underwritten by AXA PPP healthcare Limited. If **you** have selected any additional cover options, these may be provided by different insurers. At some time in the future Saga may enter into an agreement with a new provider for all or part of your **policy**, in which case this new provider will offer **you** private medical insurance to replace your current **policy**. If this is the case, Saga will write to **you** to confirm the details of the new provider and give **you** details of any changes to the Terms and Conditions of your **policy**. **You** hereby authorise Saga to transfer any personal data to a new provider, including health or other data defined as 'sensitive personal data' under the Data Protection Act, and consent to the new provider being able to offer cover to **you**. If at any time **you** wish to withdraw your agreement to this, please let **us** know by calling 0845 300 0867.

Legal rights and responsibilities

12.1 Your rights and responsibilities

- (a) Your **policy** is for one **year**. Prior to the end of any **policy year** Saga will write to the **policyholder** to advise on what terms the **policy** will continue, provided the **policy** you are on is still available. If Saga does not hear from the **policyholder** in response they will renew your **policy** on the new terms. Where **you** have opted to pay premiums by Direct Debit Saga may continue to collect premiums by such method for the new **policy year**. Please note that if Saga does not receive your premium, **you** will not be covered. If the **policy** you were on is no longer available **we** will do **our** best to offer **you** cover on an alternative policy.
- (b) **You** must make sure that whenever **you** are required to give **us** any information all the information **you** give **us** and Saga is sufficiently true, accurate and complete so as to present to **us** fairly the risk **we** are taking on. If **we** discover later it is not then **we** can cancel the **policy** or apply different terms of cover in line with the terms **we** would have applied had the information been presented to **us** fairly in the first place.
- (c) **You** and **we** are free to choose the law that applies to this **policy**. In the absence of an agreement to the contrary, the law of England and Wales will apply.
- (d) **You** must write and tell Saga if **you** change your address.
- (e) Only the **policyholder** and **we** have legal rights under this **policy** and it is not intended that any clause or term of this policy should be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999, by any other person including any **family member**.
- (f) **You** must pay your premium when it is due.
- (g) The **policyholder** may cancel this **policy** by contacting Saga during the 14 day cooling off period. The 14 day cooling off period commences on the day that the contract is concluded or the day that full **policy** terms and conditions are received, whichever is the later. The 14 day cooling off period also applies from each renewal date. If the **policy** is cancelled during the 14 day cooling off period **we** will return any premium paid for the **policy** providing no claims have been made on the **policy** in relation to the period of cover before cancellation (being no more than 14 days' cover).

If **you** incur **eligible** claims costs within that period of cover **we** reserve the right to require the **policyholder** to pay for the services **we** have actually provided in connection with the **policy** to the extent permitted by law and any return of premium is subject to this. If the **policyholder** does not cancel the **policy** during the cancellation period the **policy** will continue on the terms described in this handbook for the remainder of the **policy year**.

A refund of premium will only be made for **policy** cancellations outside the 14 day cooling-off period described in 12.1(g) in circumstances where the **policyholder** dies. In this situation a pro-rata refund will be made in relation to the unused period of cover.

- (h) If for any reason **you** decide to cancel your **policy** let Saga know by calling or writing to Saga's Customer Care Team, Saga Services Limited, Middelburg Square, Folkestone, Kent CT20 1AZ. They will then write to **you** and confirm that your **policy** has been cancelled.

12.2 Saga and AXA PPP healthcare's rights and responsibilities

- (a) Saga will tell the **policyholder** in writing the date the **policy** starts and any special terms which apply to it.
- (b) **We** can refuse to add a **family member** to the **policy** and **we** will tell the **policyholder** if **we** do.
- (c) **We** will pay for **eligible** costs incurred during a period for which the premium has been paid.
- (d) If **you** break any of the terms of the **policy** which **we** reasonably consider to be fundamental, **we** may (subject to 12.2(e)) do one or more of the following:
 - refuse to make any benefit payment or if **we** have already paid benefits **we** can recover from **you** any loss to **us** caused by the break;
 - refuse to renew your **policy**;
 - impose different terms to any cover **we** are prepared to provide;
 - end your **policy** and all cover under it immediately.
- (e) If **you** (or anyone acting on your behalf) make a claim under your **policy** knowing it to be false or fraudulent, **we** can refuse to make benefit payments for that claim and may declare the **policy** void, as if it never existed. If **we** have already paid benefit **we** can recover those sums from **you**. Where **we** have paid a claim later found to be fraudulent, (whether in whole, or in part), **we** will be able to recover those sums from **you**.
- (f) **We** can change all or any part of the **policy** from any renewal date. **We** will give **you** reasonable notice of changes to your **policy** terms.
- (g) This **policy** is written in English and all other information and communications to **you** relating to this **policy** will also be in English.

13 Glossary

Throughout this handbook certain words and phrases appear in **bold**. Where these words appear they have a special medical or legal meaning. These meanings are set out below.

Please note: Some of these words and phrases may not be applicable to your chosen plan.

To aid customer understanding certain words and phrases in this glossary have been approved by the Association of British Insurers and the Plain English Campaign. These particular terms will be commonly used by most medical insurers and are highlighted below by a **◇** symbol.

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.

Benefits table - the table applicable to this **policy** showing the maximum benefits **we** will pay **you**.

Cancer ◇ - a malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Chronic condition ◇ - a disease, illness, or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, checkups, 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 practitioner - a practising member of certain professions allied to medicine who, in all cases, meets **our** recognition criteria for benefit purposes in their field of practice and who **we** have told in writing that **we** currently recognise as a clinical practitioner for benefit purposes. However, **we** will only pay **out-patient treatment** benefits for such services when a GP or **specialist** refers **you** to them. When such persons provide such services to **you** as part of your **in-patient treatment** or **day-patient treatment** those services will form part of the **hospital** charges. The professions concerned are dieticians, **nurses**, orthoptists, physiotherapists, psychologists, psychotherapists and speech therapists. A full explanation of the criteria **we** use to determine these matters is available on request.

Complementary practitioner - a medical practitioner with full registration under the Medical Acts, who specialises in homeopathy or acupuncture or a practitioner in osteopathy or chiropractic who is registered under the relevant Act; and who, in all cases, meets **our** criteria for complementary practitioner recognition for benefit purposes in their field of practice, and who **we** have told in writing that **we** currently recognise

as a complementary practitioner for benefit purposes in that field for the provision of **out-patient treatment** only. A full explanation of the criteria **we** use to decide these matters is available on request.

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

Day-patient unit - a centre in which **day-patient treatment** is carried out. The units **we** recognise for benefit purposes are listed in the **Saga Countrywide Hospital List**.

Diagnostic tests ◇ - investigations, such as x-rays or blood tests, to find out or to help to find the cause of your symptoms.

Eligible - those **treatments** and charges which are covered by your **policy**. In order to determine whether a **treatment** or charge is covered all sections of your **policy** should be read together, and are subject to all the terms, benefits and exclusions set out in this **policy**.

Family member - (1) the **policyholder's** current spouse or civil partner or any person (whether or not of the same sex) living permanently in a similar relationship with the **policyholder**
(2) any of their or the **policyholder's** unmarried children. Unmarried children cannot stay on your **policy** after the renewal date following their 21st birthday (or 25th birthday if in full-time education).

Hospital - a hospital listed in the current **Saga Countrywide Hospital List**.

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

Medical condition - any disease, illness or injury, including psychiatric illness.

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

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

Policy - the insurance contract between **you** and **us**. Its full terms are set out in the current versions of the following documents as sent to **you** from time to time:

- any application form relating to this **policy**
- these terms and the **benefits table** setting out your cover
- your Membership Statement and **our** letter of acceptance
- any Statements of Fact **we** have sent **you**
- any endorsements Saga has sent **you**
- the **Saga Countrywide Hospital List**.

Policyholder - the first person named on the **policy** Membership Statement who must be 50 or over.

Saga Countrywide Hospital List - a document Saga publishes which lists the **hospitals**, **day-patient units** and **scanning centres** in the **United Kingdom** covered by the **policy**. The facilities listed may change from time to time so **you** should always check with **us** before arranging **treatment**.

Scanning centre - a centre in which **out-patient** CT (computerised tomography), MRI (magnetic resonance imaging) and PET (positron emission tomography) is performed. The centres **we** recognise for benefit purposes are listed in the **Saga Countrywide Hospital List**.

Specialist - a medical practitioner with particular training in an area of medicine (such as consultant surgeons, consultant anaesthetists and consultant physicians) with full registration under the Medical Acts, who meets **our** criteria for specialist recognition for benefit purposes, and who **we** have told in writing that **we** currently recognise as a specialist for benefit purposes in their field of practice.

For **out-patient treatment** only: a medical practitioner with full registration under the Medical Acts, who specialises in psycho-sexual medicine, orthopaedic medicine, manipulative or sports medicine, or a practitioner in surgical dentistry or podiatric surgery who is registered under the relevant Act; and who, in all cases, meets **our** criteria for limited specialist recognition for benefit purposes in their field of practice, and who **we** have told in writing that **we** currently recognise as a specialist for benefit purposes in that field for the provision of **out-patient treatment** only.

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

Surgical procedure - an operation or other invasive surgical intervention listed in the Schedule of Procedures and Fees.

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

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

United Kingdom (UK) - Great Britain and Northern Ireland, including the Channel Islands and the Isle of Man.

We/us/our - AXA PPP healthcare.

Year - twelve calendar months from when your **policy** began or was last renewed.

You - the **policyholder** and any **family member** named on the **policyholder's** Membership Statement.

Appendix

Frequently asked questions

This section applies to policyholders who did not provide their medical history on joining and have chosen the moratorium method of underwriting for their cover. Your Membership Statement will indicate if this applies to you. Full information on how the moratorium method of underwriting works is shown in the 'Existing medical conditions' section of this handbook.

What is the advantage of moratorium underwriting?

With this option, we ask you to give only basic information about yourself and any members of your family you wish to insure. We will not ask you to give details of your medical history, but it relies on you to understand that we will not cover treatment of any medical condition which was in existence at any time during the last three years (or five years if you joined this policy on or before 15 November 2005) immediately before your policy started or any specified related conditions to pre-existing diabetes, prostate conditions or hypertension, as shown in Section 5.

To help you understand how the moratorium method of underwriting works in practice we have set out a series of model Questions and Answers to the typical queries often raised:

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

As you will never be able to go for the period of two consecutive years without medication, cover for this or any specified related condition would be permanently excluded. Please note that if you joined on or after 16 November 2005 and have chosen to include cover for eligible treatment for pre-existing hypertension and related conditions, this does not apply to you. Your Membership Statement will indicate if this cover is included on your policy.

Some time after my cover begins I go to my doctor for a routine visit. A heart condition is diagnosed and it must have started to develop before my policy began. What is the position?

You would be covered provided that there were no symptoms evident at the time your policy commenced and you had no previous treatment for diabetes or hypertension.

What if I suspect that I am suffering from a condition (for example, I have a lump) but have not seen a doctor about it, nor received any firm diagnosis before my cover starts? Will I be covered if I need to have any investigations or treatment for the condition once my policy has started?

You would not be covered for any treatment you would need to have because of the swelling. This is because symptoms were evident when you took out the policy.

I had an operation on my knee recently. Will I be covered for any further treatment to it after my policy starts?

You would not be covered for any further treatment relating to your knee operation, or the condition for which it was performed, during your first two years of continuous cover with us. After that time provided you have had no treatment, medication or medical advice, including post operative checks, for your knee problem in the preceding two years then you would be covered for any further treatment.

What if I am uncertain whether treatment I received before the start of my policy 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 policy, you must submit a fully completed claim form to us to gain written preauthorisation for your claim. This way we will be able to establish the full facts about your condition and proposed course of treatment and will confirm our decision to you in writing before you incur the costs of treatment.

How do regular checkups affect the moratorium?

It depends on what checkups are for. For example:

If you have a specific condition before your policy starts and your doctor or specialist recommends that you continue to have checkups for that condition, then we will not cover the cost of private treatment received for that condition, or specified related condition (where appropriate), for a period of two years from the time your policy started. Cover will then only apply once you have been discharged from care and have no further treatment, medication, special diets or advice for a continuous period of two years. In the same situation described above, if you chose to continue having checkups for your own peace of mind even though you have been discharged from care, we will cover you for that condition (though not the routine checkups) if you do not need any medication, treatment, special diets or advice for a continuous period of two years. If you have general health checkups simply in the interest of maintaining good health and not for any particular condition, we ignore them when applying the moratorium.

Note: We do not pay for checkups in any of the circumstances described above.

NOTE: Please note that the preceding questions and answers provide broad guidance to the operation of the moratorium method of underwriting. 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.

If you require a large print, audio or braille version of this document please call 0845 300 0867.

If you have a hearing or speech impairment, you can also contact us by e-mailing dda@saga.co.uk

Saga Services Limited has arranged for its private medical insurance to be underwritten by AXA PPP healthcare Limited, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL.

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