

Underwriting methods and chronic conditions

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Section A

Introduction

Insurance policies provide cover against an unexpected event happening after the start of the policy. In health insurance, this means cover for the cost of private medical treatment for a curable short-term illness or injury (commonly known as acute conditions) arising after your policy starts.

Like all other medical insurance providers, there are certain things your policy is unable to cover in any event. For example, emergency treatment – which the NHS is still best able to provide – and treatment for chronic long-term illness. Other things that it will not cover include AIDS and related illnesses, willful self-inflicted injuries, routine pregnancy, cosmetic treatment, regular renal dialysis and routine visits to your GP or dentist.

Your policy will not normally cover treatment for medical conditions which you already have when your policy starts, or have had in the recent past – these are called 'pre-existing conditions'. Nor does the policy usually cover conditions which are related to pre-existing conditions. A related condition is any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury. For example, high blood pressure is related to heart disease, and recurrent sore throats are related to tonsillitis.

This section explains how we deal with pre-existing conditions.

Please note

This guide explains how we deal with pre-existing conditions generally, some policies only provide cover for treatment of specific medical conditions. The Membership Handbook of your chosen plan gives full details of the cover provided. It is important that you read your Membership Statement together with your other policy documents. In some circumstances you may have the option to retain any medical underwriting applied by your previous insurer when you join. If this is the case, please refer to your Membership Statement for confirmation of your cover for pre-existing medical conditions. Section A and B of this leaflet do not apply if you join on this basis.

A specimen copy of the Membership Handbook with full policy details is available on request if you wish to see it before applying for cover. In any event, you will also have 14 days from the time you receive your full membership pack to review the policy details. If, during this period, you tell us that you have changed your mind, we will send a full refund of any premiums you have paid, provided you have not already made a claim.

Private medical insurance from Saga is underwritten by AXA PPP healthcare Limited, therefore any reference to 'we, us, our' in this document means AXA PPP healthcare Limited.

Section B

Choosing your underwriting method

On some policies, if you join on or after 16 November 2005 you may be able to choose to include cover for eligible treatment for hypertension. If you do choose such cover then you will be able to claim for eligible treatment of hypertension and related conditions, irrespective of it being a pre-existing medical condition. However, treatment of all other medical conditions will be subject to our rules on moratoriums or full medical history assessments, whichever underwriting method applies to you.

Your underwriting options explained

We offer you a choice of two ways of applying for cover. Whichever method you choose, the premium for the plan you select will be the same, as existing conditions are automatically excluded from your policy (although in some circumstances we may agree to include them if you join by declaring your medical history). Like any new insurer, we will not cover you for a condition that you are currently receiving or have recently had treatment for and for which you may currently be covered with another insurer.

1. Moratorium

With this option, you do not need to fill in a medical history declaration. Instead, we automatically exclude treatment for any medical condition or related condition which you (and any member of your family included in your application) have received treatment and/or medication for, or had symptoms of, or asked advice on, or were aware of, during the three years (or five years if you joined a Saga HealthPlan policy on or before 15 November 2005) immediately before your policy started.

However, if you do not have any treatment, medication, or advice for those pre-existing medical conditions, and any related medical conditions, for two continuous years after your policy starts, then the conditions may become eligible for benefit subject to the terms of your policy.

Please understand that your policy will probably never cover pre-existing chronic conditions which are likely to continue to need regular or periodic treatment, medication, or medical advice.

This is because you will always need to have medical advice or take medication and therefore you will never be able to go for the period of two years without advice or medication. Those medical conditions are therefore completely excluded for all time. Of course, any new unexpected medical conditions arising after the start of your policy will be covered immediately subject to the terms of your policy.

Note

We strongly advise you not to delay seeking medical advice and treatment for a pre-existing medical condition during the moratorium simply to obtain cover during your policy.

2. Full medical history assessment based on completing a medical history declaration

If you choose this option, your answers to the questions will enable us to understand your medical history (and that of any member of your family whom you wish to insure). It is important that you consider the questions carefully for each person to be covered, and answer them fully. We will review the details and decide the basis on which we can accept you (and any members of your family) for cover. If necessary, we will ask your doctor for any further information we need to help us to do this. If you have any pre-existing medical condition that is likely to need treatment in the future, we will usually exclude it from cover and any conditions related to it. We will show any exclusions on the Membership Statement you receive from us when we have processed your application. (The same process will also apply for any members of your family included in your application.)

If we exclude treatment for a pre-existing medical condition when your policy first starts, we will, in some cases, offer to review the exclusion in the future, if you wish. Usually, we will not remove an exclusion for a chronic condition as it is always likely to need regular or periodic treatment.

Of course, any new medical conditions arising after the start of your policy will be covered immediately subject to the terms of your policy.

Note

You must ensure that you provide full and accurate information in answer to the questions in the medical history declaration. Failure to do so may mean that we cannot cover a claim, or even that your policy is void. If you are unsure whether we would want to know a particular fact, we advise you to tell us about it.

Examples of how the two underwriting methods work

Q Which underwriting option should I choose – moratorium or full medical history assessment?

A You can choose the underwriting method that suits you best. In any event, your policy will only cover treatment of unexpected medical conditions arising after you join, but not pre-existing medical conditions.

Moratorium - When you opt for the moratorium, we ask you to give only basic information about yourself and any members of your family whom you wish to insure. We will not ask you to give details of your medical history, but we rely on you to understand that we will not cover treatment of pre-existing medical conditions.

The only exception is when you remain free of all treatment, medication, advice or symptoms for the medical condition, and any related medical conditions, for a continuous period of two years after you join.

Full medical history assessment - If you opt for a full medical history assessment, this may involve a little more of your time when completing the proposal form. But it does mean that when we send your membership pack we will confirm in writing which medical conditions would be excluded from cover. We may later cover a pre-existing medical condition if you ask us to review the exclusion and we agree to remove it.

Q What if I suspect 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?

A **Moratorium** - Because you have a symptom of the medical condition before your cover starts, even though you are not sure exactly what it is, the costs of receiving any private treatment for the medical condition, and any related medical conditions, will not be covered by your policy.

Full medical history assessment - You would be expected to disclose the symptom on your medical history declaration. Treatment for those symptoms and the underlying causes of them, and any related medical conditions, would be excluded from benefit.

It is probable that we would ask for more information when you applied to join so that you and we would know exactly what was being excluded from benefit.

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

A **Moratorium** - Providing you do not have any symptoms or need any treatment, advice or medication, including post-operative checks for your medical condition for two clear years after your policy starts, then should that medical condition recur after this period you would be covered for any further treatment needed to cure it, subject to the terms of your policy.

Full medical history assessment - Treatment for this condition would be excluded from cover. However, we would be willing to review this position in the future (the timing of the review would depend on how recent the operation had been).

Q Some time after my cover starts, I go to my doctor for a routine visit. A heart condition is diagnosed which must have started to develop before my policy started. What is the position?

A **Moratorium** - The moratorium clause only applies to any medical condition, or related medical condition (or both), which you were aware of in the three years (or five years if you joined a Saga HealthPlan policy on or before 15 November 2005) before your policy started.

So if:

- the heart condition was first diagnosed after your policy started, and
 - you had no previous treatment for any related medical condition, such as high blood pressure or chest pains, and
 - you had no symptoms before your policy started;
- cover would be available even if it was proved that the medical condition must have existed before your policy started.

Full medical history assessment - You would be covered for the heart condition provided that there were no symptoms relating to your heart condition and you had no previous treatment for any related conditions, such as chest pains, which you should have disclosed at the time your policy commenced.

Q How do regular checkups affect the moratorium?

A It depends what the checkups are for. For example:

- i) If you have a specific medical condition before your policy starts and your doctor, or specialist, recommends that you continue to have checkups for that medical condition, then we will not cover the cost of private treatment received for that medical condition. Cover will only apply once you have been discharged from care and have no further treatment, medication or advice for a continuous period of two years.
- ii) In the same situation described above, if you choose to continue having checkups for your own peace of mind even though you have been discharged from care, we will cover you for that medical condition (though not the routine checkups) if you satisfy the terms of the moratorium (in other words, you do not need any medication, treatment, advice or suffer any symptoms for two continuous years).
- iii) If you have general health checkups simply in the interests of maintaining good health, and not for any particular medical condition, we ignore them when applying the moratorium.

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

Section C

Chronic conditions

In common with other annual insurance policies, medical insurance is designed to cover claims for expenses incurred as a result of unexpected events. Therefore, it is important to understand when buying medical insurance that policies are designed to cover treatment of medical conditions that respond quickly to treatment, referred to by us as 'acute conditions'. Medical insurance is not intended to cover you against the cost of recurrent, continuing or long-term treatment of chronic medical conditions since these treatments become a series of predictable, rather than unexpected, events.

The following information is designed to help you understand more about what we mean by a chronic condition and provide practical examples of when we will or will not cover treatment of those conditions.

What is a chronic condition?

A 'chronic condition' is 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.

We cover the cost of treatment for acute conditions. That is, treatment which aims to return you to the state of health you were in before suffering the condition, or which leads to your full recovery. This includes short-term medical intervention to treat unexpected complications or exacerbations of a chronic condition.

If your illness or medical condition requires recurring consultations over a long period, checks on your medication, long term therapy or treatment to ease symptoms, your condition may fall within the definition of a chronic condition. If you have been receiving ongoing or continuing treatment or treatment that is intended to manage your condition or keep your symptoms in check, we will review your treatment to assess whether it remains eligible for benefit.

What does this mean in practice?

For claims that have been authorised prior to treatment, we will tell you if we think your condition is now a chronic condition under our rules.

We may then (with your permission) contact your specialist or GP who knows your particular circumstances. We may ask them to confirm to us the diagnosis of your condition, details of the treatment you are currently receiving and give us a future prognosis for the condition.

In line with other medical insurance policies, our plans are designed to cover claims for expenses incurred as a result of unexpected events and we do not go on paying for recurring or continuing treatment of medical conditions that will continue indefinitely or keep recurring. Should the information we have indicate that you have a chronic condition we will write to tell you we will stop paying benefit for the continuing or recurrent treatment of the chronic condition.

What if your condition gets worse

We will pay for the treatment of acute exacerbations or complications (flare-ups) in order to bring the condition quickly back to its controlled state, (for instance in-patient treatment needed to re-stabilise a chronic condition such as diabetes). There are certain other chronic conditions such as Crohn's disease which, because of their nature, require management of recurrent episodes during which the symptoms of the condition worsen. Because of the ongoing or continuing nature of the condition, we will write to tell you when there is no further benefit available for the treatment of that medical condition.

Examples of chronic conditions

The following are examples of chronic conditions and how we usually deal with them. In all of the following examples we may need to write to you or your doctor to obtain further information, as explained above.

Important note - certain plans have specific restrictions to benefits such as out-patient treatment, treatment that could have been received on the NHS within four or six weeks and other specific exclusions covered in the customer's policy terms. The cover for cancer also varies by product with some products having lower levels of cover than those described in this document. The examples below are designed to show our general policy on chronic conditions and how we would deal with them for a customer on a mid-range policy. Please read your handbook carefully to establish what cover you have, as all the other terms (including any limits) of your policy will continue to apply to your cover.

Example 1 - Angina and heart disease

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

We would pay for the initial consultation and tests to diagnose the condition and further consultations with the specialist to allow the medication to bring the condition under control. At this point we would advise Alan that further regular review consultations to monitor the condition would not be covered, but we would allow one further consultation to allow Alan to discuss alternative arrangements should he wish to do so.

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

We would confirm to Alan that we will cover that operation as it will stabilise his condition and substantially relieve his acute symptoms. We would then explain to Alan that, although his policy would not normally cover regular checkups, in this particular circumstance we would allow for a further ten years of annual postoperative checkups with the specialist to ensure that his condition remains stabilised. This benefit would only be available on policies with out-patient cover and while the policy remains in force.

Example 2 - Asthma

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

We would agree to cover Eve's initial tests and consultation to establish the diagnosis and also the subsequent consultation to see if there was an improvement.

However, we would then advise Eve that regular checkups are outside the scope of her cover.

Eighteen months later, Eve has a bad asthma attack.

We would agree to cover the cost of hospital treatment until her condition has been stabilised. We would also pay for one further consultation following discharge from hospital.

Example 3 - Cancer

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

We would pay for the breast to be removed and initial reconstruction to restore appearance. In addition we would also pay for the course of radiotherapy and licensed chemotherapy aimed at bringing the condition into remission or cure. Hormone therapy tablets (such as Tamoxifen) are out-patient drugs and, in line with other out-patient drugs, are not covered by our policies.

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

We would pay for treating the recurrence as described above for the initial breast cancer.

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

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

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

- We would pay for the course of licensed chemotherapy aimed at bringing the condition into remission or cure.
- We will pay for up to three months for the infusions of licensed drugs to help protect the bones against pain and fracture.
- We will pay for the licensed drugs to suppress the growth of the cancer (e.g. Herceptin). These chemotherapy treatments that are given for prolonged periods would normally fall outside benefit but, in the case of cancer, we make an exception. Thus the use of such drugs will be covered for a period of time as described in your policy document or for the period of the drug's licence if this is shorter.

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

Hospice care is provided by the NHS and charitable institutions at no cost to the patient and we would not therefore cover this.

Example 4 - Diabetes

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

We would explain that we cannot continue to provide benefit for the review consultations but, would agree to provide benefit for one more to allow Deirdre the opportunity to discuss alternative arrangements for follow up.

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

We would provide benefit for this admission and for a short period after her discharge.

Example 5 - Hip pain

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

We would explain that the monthly visits are not covered by Bob's policy but that, if he should have further problems or if his condition should worsen to the point where a hip replacement is needed, this would be covered if his GP refers him to a suitable specialist.

Please note that only certain policies cover complementary therapies such as osteopathy and you should check your Membership Handbook to see if this is the case.

Section D

Access to Medical Reports Act (1988)

Before we can assess any application, we may need to get a medical report from a doctor who has cared for the patient. The Access to Medical Reports Act (1988) gives the patient certain legal rights. These are:

- We need their agreement before we can apply for a medical report from their doctor. They can refuse, but if they do, we will not be able to assess their application.
- The patient can ask to see the report before their doctor sends it to us, or for up to six months after it has been sent.
- If the box on the medical history declaration form is ticked to indicate that the patient wants to see the report, their doctor can charge a reasonable fee to cover costs of supplying a copy.
- If the patient thinks any part of the report is incorrect or misleading when they see it, they can ask to have it changed. If their doctor will not agree to do this, the patient may attach a statement of their own.

The doctor is not obliged to let the patient see any part of a report if:

- The doctor believes it could seriously harm their physical or mental health, or that of others.
- Indicates the doctor's intentions in respect of them.
- Reveals information about another person, or the identity of someone who has given the doctor information about them (unless that person consents or is a health professional involved in caring for the patient).

We will write and tell the patient when we have requested the report. If the patient asked to see the report before their doctor sends it to us, they will have 21 days to contact their doctor from the date of receipt of our letter. Once they have seen the report, their doctor needs their agreement to send it to us. If they don't arrange to see this report within 21 days, their doctor will be free to send it to us.

Section E

Data Protection - To be read by all applicants

AXA PPP healthcare Data Protection

AXA PPP healthcare will use personal information to process claims, for underwriting and pricing purposes and to maintain management information for business analysis. AXA PPP healthcare may disclose personal information, under the protection of a contract, to Saga for the purposes listed below or service providers to administer the policy, or to those involved with your treatment or care. This may include another company based outside the European Economic Area. Claims correspondence will be addressed to the policyholder. If a family member does not wish us to correspond with the policyholder in relation to their claim, and they are aged 18 or over, they should take out a separate plan in their own name. To continuously improve our service to members, your calls may be recorded and monitored. If you wish to access your personal information please write to Chris Spray, Data Protection Manager at AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL, and ask for a "Data Subject Access Form".

Saga Data Protection

Saga will keep your personal 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, for underwriting and pricing purposes and in certain circumstances claims mediation and market research and to maintain management information for business analysis. Saga may share your personal information and your medical data with other Saga Group companies. By providing us 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 they consider to be of interest to you. We will do this unless you contact us or you make use of the regular opportunities that we provide you with, to confirm which channels and products you do and do not wish to use or hear about, or unless you tell us you prefer not to receive direct marketing.

Section F

This Guarantee should be retained by the Payer



The Direct Debit Guarantee

- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change, Saga Services will notify you 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by Saga Services or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

Saga Private Medical Insurance

0800 904 7409

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

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