Your Policy Book

HealthPlan Saver Plus, Saver Plus 4 Week Wait and Saver Plus 6 Week Wait

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Contents

Section

Contacting us

While it is important that you read and understand your Policy Book, 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 0800 027 1331 when you need **treatment**. Please remember you must obtain 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 Plus, Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6 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 GP Service
0800 027 1333

(operated by Medical Solutions UK Limited)
Available day or night, 365 days a year.

Saga Health Information Line
0800 17 40 17

Available day or night, 365 days a year.

For more information on access to these advice and support lines, please see section 11.

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

Claims Personal Advisory Team
0800 027 1331

If calling from outside the UK
+44 1892 503016 – international call rates apply.

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

Fax: 01179 726100

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

To discuss or make changes to your Saga HealthPlan

Customer Care Team
0800 056 9273
Or call 02082 822946

Available: Monday to Friday 8.30am-7pm, Saturday 9am-1pm, Sunday 10am-2pm.

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

For example, our Claims Personal Advisory Team can be contacted by Next Generation Text on **18001 0800 027 1331** 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.

Welcome to Saga HealthPlan Saver Plus

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 Policy Book 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, that your policy gives you the cover you want and that you are aware of the additional advice and support lines available to you as a Saga Health Insurance customer.

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

1 Introduction

The purpose of this Policy Book and how to use it

This Policy Book sets out the terms of cover for Saga HealthPlan Saver Plus, Saver Plus 4 and Saver Plus 6. If you are unsure of which particular **policy** you have, please refer to your Policy Schedule. (Please note that Saga HealthPlan Saver Plus 4 and Saver Plus 6 are not available if you live in the Channel Islands or Isle of Man.)

Your **policy** is an annual insurance contract which means that 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 Policy Book 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 Policy Book 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 or, if they apply to a specific section, they will be defined there.

Additionally, when we refer to 'you' or 'your' throughout this document, we mean the **policyholder** and any **family members** named on the **policyholder's** Policy Schedule.

Please note:

This Policy Book 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.

This Policy Book includes wording for both Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6. If you have chosen one of these options this will be detailed on your Policy Schedule. Saga HealthPlan Saver Plus 6 is only available from the second **policy year** onwards.

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 Saga HealthPlan Saver Plus, Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6

The Saga HealthPlan Saver Plus, Saver Plus 4 and Saver Plus 6 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 section 5 'Existing medical conditions' 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
- unlimited follow-up CT, MRI and PET scans performed within eight months after related, **eligible in-patient** or **day-patient treatment**, or after a related **out-patient surgical procedure**
- up to £1,000 of benefits for **out-patient diagnostic tests**, **out-patient** consultations (including post-operative consultations), and **therapists'**, **physiotherapists'**, **acupuncturists'**, **homeopaths'** and **practitioners'** charges.

Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6:

*With a '4 Week Wait' or '6 Week Wait' plan, if the NHS can give you the hospital **treatment** you need within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed, then you must use the NHS. For more information, please see the '**Benefits table**' section starting on page 6 and the 'Your cover for cancer treatment' section starting on page 20.*

***Please note**: Saga HealthPlan Saver Plus 4 and Saver Plus 6 are not available if you live in the Channel Islands or Isle of Man.*

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 section 10 'Additional information' 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?
Dental procedures other than those included under the optional Health Cash Benefits Cover	Section 6
Routine pregnancy and childbirth	Section 6
Treatment of mental health conditions	Section 6
*Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: Urgent or emergency **treatment***	*Section 4*
Charges when **treatment** is received outside of the **Saga Countrywide Hospital List** (unless the **treatment** has been approved by us in advance)	Section 8
Treatment that we have not first authorised as **eligible** for payment	Section 4

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

Please note:

You can be reassured that the vast majority of **specialists** we recognise are **fee-approved specialists** and we routinely pay their **eligible treatment** charges in full. We also pay **eligible treatment** fees in full with a **therapist** or **physiotherapist** and charges for an **acupuncturist**, **homeopath** or **practitioner** up to the level shown within the Schedule of Procedures and Fees.

We support you in identifying a suitable **treatment** provider. However, if you choose to receive **treatment** under the direction of a **fee-limited specialist** you may have to make a contribution to your **treatment** costs.

Please see section 8 'Who we pay for treatment and where you can be treated' (page 26) for full details.

If you have chosen Fixed Fast Track (not available if you live in the Channel Islands or Isle of Man):

This **policy** offers you cover for necessary **treatment** of **medical conditions** when **treatment** is received from a **selected provider**. By '**selected provider**' we mean 'a **hospital**, **day-patient unit**, **out-patient facility**, **scanning centre**, **specialist**, **practitioner**, **therapist**, **physiotherapist**, **acupuncturist** or **homeopath** that we have helped you choose to provide your **treatment**'.

Please see section 8 'Who we pay for treatment and where you can be treated' (page 28) 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 Policy Book. You must read this table in conjunction with the rest of your Policy Book.

Please make sure you call us on 0800 027 1331 prior to **treatment** so that we can confirm the extent of your cover and any limitations that may apply.

Please note:

You must obtain 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**.

Alternatively, if you have chosen Fixed Fast Track, you must call us in advance of booking any **treatment** so that we can choose the **hospital** with you.

*If you have Saga HealthPlan Saver Plus 4 or Saga HealthPlan Saver Plus 6: 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/six weeks of the **specialist** who would oversee the private **treatment** 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/six weeks of the **specialist** who would oversee the private **treatment** 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.*

*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/six weeks of the **specialist** who would oversee the private **treatment** 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 the NHS cash benefit, the **external prosthesis** benefit or the optional Health Cash Benefits Cover.

If you have chosen the optional Extended Cancer Cover, the excess does not apply to the hospital expenses cash benefit, **external prosthesis** benefit, purchase of wigs or hospice donation.

Benefits	Amount payable	For more information
In-patient and day-patient treatment		**Section**
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** or a **hospital** we have chosen with you	8
2. **Specialists**' fees (surgeons, anaesthetists and physicians).	No annual maximum	8
3. **In-patient** consultations – benefit for a consultation with a second **specialist** arranged by the treating **specialist**.	No annual maximum	8
Out-patient treatment		
4. **Surgical procedures**.	No annual maximum	6
5. **Specialist** consultations. 6. **Diagnostic tests**. 7. **Practitioner** and **physiotherapist** charges. 8. **Therapist**, **homeopath** and **acupuncturist** charges.	These four benefits (5, 6, 7 and 8) have a combined overall limit of £1,000 a **year**	8
9. **Cancer treatment**. Including charges for radiotherapy (the use of radiation to treat **cancers**) and chemotherapy (the use of drugs to treat **cancers**). Please refer to 'Your cover for cancer treatment' in section 7.	No overall annual maximum (any **eligible out-patient treatment** that took place prior to or to establish a **cancer** diagnosis would affect the monetary limits detailed in benefits 5, 6, 7 and 8 above. However, any **eligible out-patient cancer treatment** costs following a **cancer** diagnosis are not subject to these monetary limits or the eight month requirement detailed in benefit 10 (ii))	7
10. (i) One computerised tomography (CT), magnetic resonance imaging (MRI) or positron emission tomography (PET) scan. (ii) Unlimited follow-up CT, MRI or PET scans performed within eight months after related, **eligible in-patient** or **day-patient treatment**, or after a related **out-patient surgical procedure**.	Paid in full in any **scanning centre** listed in the **Saga Countrywide Hospital List** or a **scanning centre** we have chosen with you	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** • provided by a **nurse** under the direction of a **specialist** • skilled nursing care provided at your home • provided for at least 7 hours a day	8
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**. *Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: The four/six 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.*	£100 a night, up to £2,000 a **year**	8
13. **External prosthesis** benefit.	Up to £5,000 for the lifetime of your **policy**. We will pay this benefit towards the cost of providing an **external prosthesis**.	6
14. Saga Health Information Line. Confidential medical information.	Immediate access 24 hours a day, 365 days a **year**	11
15. Saga GP Service. Access to the confidential GP helpline is available in addition to your **policy**.	Immediate access 24 hours a day, 365 days a **year**	11

Benefits	Amount payable	For more information
Health Cash Benefits Cover (optional cover) The following benefits only apply if you have opted for the Health Cash Benefits Cover and are available to the policyholder and their spouse/partner only.		
16. Dental care.	Up to £200 per person covered a **year**	9
17. Optical care.	Up to £150 per person covered a **year**	9
18. Dental accident.	Up to £200 per person covered a **year**	9
19. Dental emergency.	Up to £200 per person covered a **year**	9
20. Health assessment.	Up to £150 per person covered a **year**	9
Extended Cancer Cover (optional cover) The following benefits are available if you have opted for the Extended Cancer Cover benefit in addition to those shown in the Extended Cancer Cover table on page 23.		
21. Hospital expenses cash benefit. This benefit is paid out upon diagnosis of **cancer**.	Maximum £100 a **year**	7
22. Additional expenses incurred to support you whilst you are undergoing **active treatment of cancer**: (i) Purchase of wigs (ii) Provision of external prostheses following surgical **treatment**.	 Up to £150 a **year** Up to £5,000 a **year**	7
23. Hospice donation. This charitable donation is paid for each night you receive end of life care related to **cancer** in a registered hospice or hospice at home.	£100 a night up to a maximum of £2,000	7

Please note: if you have an excess on your **policy**, it will not be affected by the NHS cash benefit, the **external prosthesis** benefit, the hospital expenses cash benefit, purchase of wigs or hospice donation, or by the Health Cash Benefits Cover if you have opted for this.

Your No Claim Discount (NCD) will not be affected by **eligible treatment** with a **therapist**, **homeopath**, **acupuncturist** or **physiotherapist**, the NHS cash benefit, the **external prosthesis** benefit, the hospital expenses cash benefit, purchase of wigs or hospice donation, or by the Health Cash Benefits Cover if you have opted for this.

4 Arranging treatment and making a claim

If you have chosen the Saga Countrywide Hospital List or our London Upgrade, or you live in the Channel Islands or Isle of Man, the following information and that on page 13 applies:

(If you have chosen Fixed Fast Track, please see pages 11-13.)

Please remember that you must obtain 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**.

Please note:

There may be occasions when you will not need to complete a claim form. Your Personal Adviser will be able to confirm this to you during your call.

Fast Track Appointments Service

We have a team who can help you find a **fee-approved specialist**. This service is available if your **GP** has given you an **open referral**, meaning they do not specify the **specialist's** name.

We can also support you if you would like an alternative to the **specialist** your **GP** has referred you to. In many cases we can book the appointment with the **specialist** for you.

You can also use our Fast Track Appointments Service if you would like a second opinion from another **specialist** as part of an **eligible** claim. Simply call us and we can discuss the options with you.

Please note:

Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6:

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

Working Body

When you experience muscle, bone or joint pain, it is important that you get the most appropriate support early. With 'Working Body' you can get access to advice and **treatment** without the need for a **GP** referral. If you use Working Body for advice this will not affect your existing benefits, as it works alongside these benefits. However, if a Working Body **physiotherapist** recommends **treatment**, then we may need to make some checks before any **treatment** can be authorised and claims are paid, subject to the terms of your **policy**.

Please note:

Family members under the age of 18 will need to see their **GP** for a referral for these conditions, as the Working Body service is not available to them.

To ensure your claim proceeds smoothly, please follow these simple steps (If you have selected Health Cash Benefits Cover as detailed in the benefits table, please refer to section 9 for details of how to make a claim under this cover.)

Step One	Your **GP** refers you to a **specialist** for private **treatment**. (For muscle, bone and joint pain – see the 'Working Body' explanation on this page.)
Step Two	You need to call us on **0800 027 1331** 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. Please help us by having the following details available: • **Specialist/Specialist** type or group practice name • **Hospital** name and any admission dates • A procedure code if you are having a **surgical procedure** • Details of your **medical condition** particularly if your **policy** excludes cover for **treatment** of pre-existing conditions.
Step Three	We will then: • Check that we will pay the **specialist's** fees in full or find a **specialist** for you • Confirm which **hospitals** are covered • Send you a partially completed claim form.
Step Four	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. Ask your **GP** to complete the remainder of the claim form and return it to us at the address shown on the form.
Step Five	Once we have received your completed claim form we will then: • Assess the claim and confirm whether we will cover the **treatment** • Remind you of any benefit restrictions that may affect your claim. (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.)
Step Six	Send in any outstanding accounts for **treatment** to our Claims Personal Advisory Team.

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

What happens if I require emergency treatment?

*Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: These **policies** 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/six weeks of the **specialist** who would oversee the private **treatment** 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/six weeks. Your **policy** therefore will not cover it because of its urgent or emergency nature.*

Saga HealthPlan Saver Plus: 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**.*

If you have chosen Fixed Fast Track (not available if you live in the Channel Islands or Isle of Man) the following information applies:

(If you have chosen the Saga Countrywide Hospital List or our London Upgrade, or you live in the Channel Islands or Isle of Man, please see pages 9-10 and 13.)

When you require **treatment** we will support you by choosing a **selected provider** to treat you. To enable us to do this you must contact us before booking or receiving any **treatment**. We can book the appointment with a **specialist** for you.

Please remember that you must obtain 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.

Please note:

There may be occasions when you will not need to complete a claim form. Your Personal Adviser will be able to confirm this to you during your call.

Be aware:

Once you have started making a claim, unless we have advised you otherwise, you must contact us prior to each stage of **treatment**. If you do not do this or do not receive **treatment** with the provider we helped you choose, we may refuse payment for the **treatment** you receive and you will be liable for the whole cost of **treatment**.

GP open referral

To use Fixed Fast Track you must ensure your **GP** provides an **open referral** letter for your **treatment** before you contact us. An **open referral** is where your **GP** states that **treatment** is necessary and which type of **specialist** you require that **treatment** from, but does not specify the **specialist's** name. For example, if you have a skin condition you will need an **open referral** for **treatment** with a dermatologist.

Be aware:

If, when you call us, your **GP** has provided a referral to a named healthcare provider, we will still support you by finding a **selected provider** to treat you and assist you in arranging **treatment** with them. In some cases we may require additional information from your **GP** in order to do this.

If you have an appointment booked with a named provider prior to contacting us, we will let you know if you need to cancel this appointment. We will not be liable for any cancellation or missed appointment charges which are incurred.

Working Body

When you experience muscle, bone or joint pain, it is important that you get the most appropriate support early. With 'Working Body' you can get access to advice and **treatment** without the need for a **GP** referral. If you use Working Body for advice this will not affect your existing benefits, as it works alongside these benefits. However, if a Working Body **physiotherapist** recommends **treatment**, then we may need to make some checks before any **treatment** can be authorised and claims are paid, subject to the terms of your **policy**.

Please note:

Family members under the age of 18 will need to see their **GP** for a referral for these conditions, as the Working Body service is not available to them.

To ensure your claim proceeds smoothly, please follow these simple steps (If you have selected Health Cash Benefits Cover as detailed in the benefits table, please refer to section 9 for details of how to make a claim under this cover.)

Step One	Your **GP** provides an **open referral** for private **treatment**. (For muscle, bone and joint pain – see the 'Working Body' explanation on this page.)
Step Two	You need to call us on **0800 027 1331** 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. Please help us by having the following details available: • **Specialist** type • Preferred **hospital** name and any admission dates • A procedure code if you need a **surgical procedure** • Details of your **medical condition** particularly if your **policy** excludes cover for **treatment** of pre-existing conditions.
Step Three	We will then: • Check that the **treatment** is **eligible** based on the information provided over the phone • Send you a claim form (if required) • Find up to three **selected providers**, who you are allowed to receive **eligible treatment** from, for you to choose between • Provide you with details of the chosen **selected provider**. If you need to see a **specialist**, we can book the appointment for you. In order to book your appointment with the **specialist** we will need to share some personal information with them, including medical information. In some circumstances, it may be necessary or you may prefer to make the appointment with the **specialist** yourself.
Step Four	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. Ask your **GP** to complete the remainder of the claim form and return it to us at the address shown on the form.
Step Five	Once we have received your completed claim form we will then: • Assess the claim and confirm whether we will cover the **treatment** • Remind you of any benefit restrictions that may affect your claim. (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.)
Step Six	Send in any outstanding accounts for **treatment** to our Claims Personal Advisory Team.

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

What happens if I require emergency treatment?

*Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: These **policies** 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/six weeks of the **specialist** who would oversee the private **treatment** 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/six weeks. Your **policy** therefore will not cover it because of its urgent or emergency nature.*

Saga HealthPlan Saver Plus: 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**.*

Arranging your appointments

We have a team who can help you find a **selected provider**. By '**selected provider**' we mean 'a **hospital**, **day-patient unit**, **out-patient facility**, **scanning centre**, **specialist**, **practitioner**, **therapist**, **physiotherapist**, **acupuncturist** or **homeopath** that we have helped you choose to provide your **treatment**'.

You can also use our Fast Track Appointments Service if you would like a second opinion from another **specialist** as part of an **eligible** claim. Simply call us and we can discuss the options with you.

Please note:

Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6:

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

The following points are relevant for the Saga Countrywide Hospital List, London Upgrade and Fixed Fast Track:

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.

Do I need to tell the place where I have my treatment that I have private medical insurance with Saga?

Yes, you must tell the place where you have your **treatment** that you have private medical insurance with Saga (which is underwritten by AXA PPP healthcare). This will mean that the fees charged for your **treatment** are those AXA PPP healthcare have agreed with the **hospital** or centre.

What happens if I've paid the bills myself already or if I receive a bill?

If you paid your medical bills yourself and your **treatment** is covered, we will refund you the costs, minus any excess. Please send the original receipts from the **specialist** or **hospital** to AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL.

If you receive a bill, please call us and we'll explain what to do next.

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 authorisation for your claim from us; and
- we receive original invoices for **treatment** costs; and
- you 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 will 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 **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 another party is responsible for some of my claims costs?

4.4 You must contact us if you are able to recover any part of your claims costs from any other party, for example if you have another insurance policy, cover through a state healthcare system or are legally entitled to recover costs from another third party. We will only pay our proper share (see also 12.2(d) in the section 'Complaint and regulatory information'). We do this so that we can keep the cost of premiums down. It also means that you can potentially be repaid for any costs you paid yourself, such as your excess or any private treatment that was not covered by your **policy**.

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

4.5 You must tell us as quickly as possible if you believe something or someone else (i.e. a third party) contributed to or caused the need for your **treatment**, such as a road traffic accident, an injury or potential clinical negligence.

This does not change the benefits you can claim under your **policy** (your 'Claim') and also means that you can potentially be repaid for any costs you paid yourself, such as your excess or any private treatment that wasn't covered by your **policy**. Where appropriate, we will pay our share of the Claim and recover it from the third party.

4.6 Where you bring a claim against a third party (a 'Third Party Claim'), you (or your representatives) must:

- include all amounts paid by us for **treatment** relating to your Third Party Claim (our 'Outlay');
- include interest on our Outlay at 8% p.a;
- keep us fully informed on the progress of your Third Party Claim and any action against the third party or any pre-action matters;
- agree any proposed reduction to our Outlay and interest with us prior to settlement. If no such agreement has been sought we retain the right to recover 100% of our Outlay and interest directly from you;
- repay any recovery of our Outlay and interest from the third party directly to us within 21 days of settlement;
- provide us with details of any settlement in full.

If you recover our Outlay and interest and do not repay us this recovered amount in full, we will be entitled to recover from you what you owe us and your **policy** may be cancelled in accordance with 12.2(e) in the section 'Complaint and regulatory information'.

Even if you decide not to make a claim against a third party for the recovery of damages, we retain the right (at our own expense) to make a claim in your name against the third party for our Outlay and interest. You must co-operate with all reasonable requests in this respect.

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

If you have any questions please call **0800 027 1331** and ask for the Third Party Recovery Team.

5 Existing medical conditions

Please note:

The following defined terms apply to this section:

Medical condition – any disease, illness or injury, including mental health conditions.

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 conditions**. If this applies to you it will be shown on your Policy Schedule.

Specified condition – the **medical conditions** listed in the table opposite that we will not cover if you have the following **pre-existing conditions**: diabetes, raised blood pressure (hypertension) or you are undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test.

Trouble free – when you:

- have not had any medical opinion from a medical practitioner including **GPs** 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 **practitioner**, **therapist**, **physiotherapist**, **homeopath**, **acupuncturist**, optician or dentist;

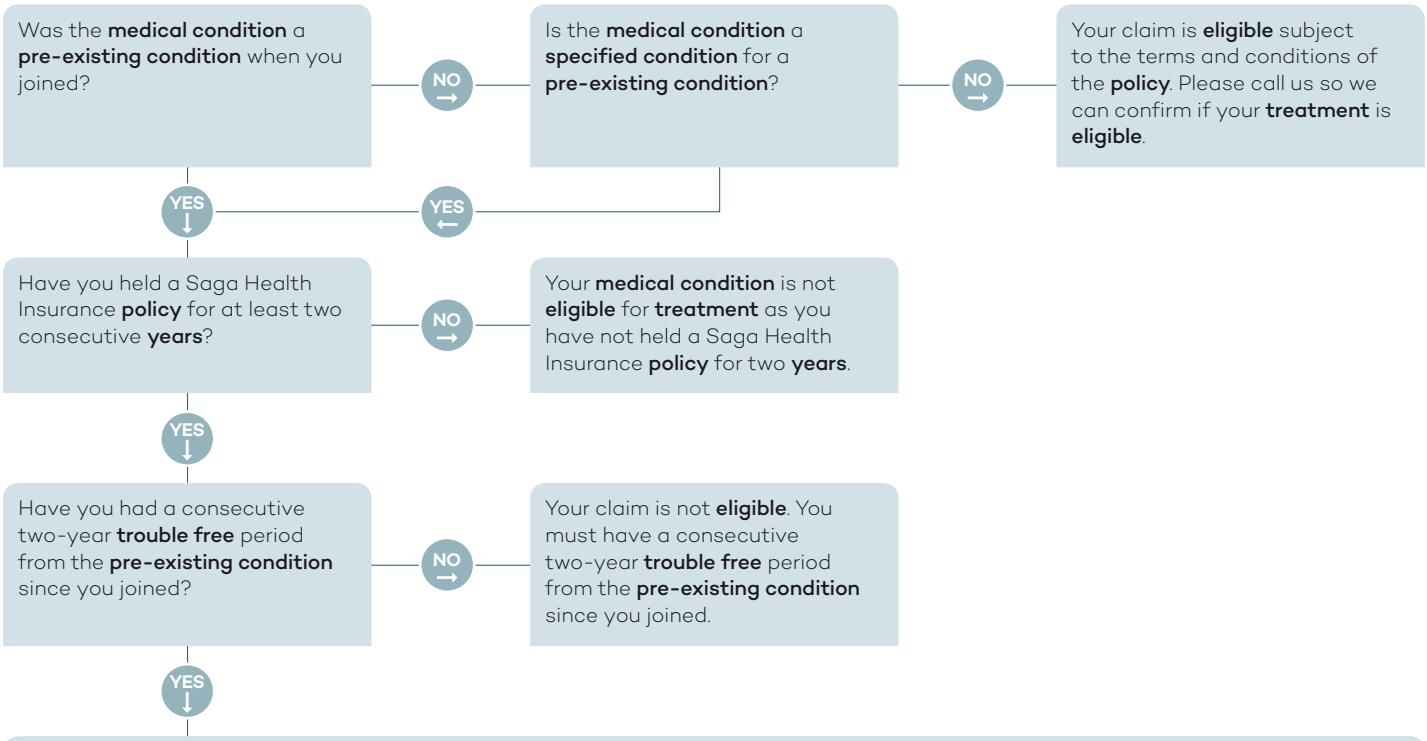
for the **medical condition**.

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 conditions** to it. If these apply to you they will be shown on your Policy Schedule.

If you completed a medical history declaration when you joined, your Policy Schedule will show the **medical 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.



Your claim is **eligible** subject to the terms and conditions of the **policy**. Please call us so we can confirm if your **treatment** is **eligible**.

Please note: We will exclude **specified conditions** from your cover for at least two **years** after you join if:

- you were already aware that you had diabetes when you joined, or
- you were already aware that you had raised blood pressure (hypertension) when you joined, or
- you were already being investigated, monitored or treated as a result of a PSA (Prostate Specific Antigen) test to do with the prostate, when you joined.

The **specified conditions** we will not cover are listed in the table on the next page. We will not cover **treatment** for these **specified conditions** whatever the cause, even if they are not related to the **pre-existing condition** or they develop after you join.

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 conditions** where you have one of the **pre-existing conditions** shown in the table below.

If you have the following pre-existing condition:	We will not pay for treatment of the following specified condition/s:
Have been diagnosed with diabetes	• Diabetes • Ischaemic heart disease • Cataract • Diabetic retinopathy • Diabetic renal disease • Arterial disease • Stroke
Have had **treatment** for raised blood pressure (hypertension) in the three years before you joined*	• Raised blood pressure (hypertension) • Ischaemic heart disease • Stroke • Hypertensive renal failure
Have been under investigation, had **treatment** or undergone monitoring as a result of a Prostate Specific Antigen (PSA) test in the three years before you joined	• Any disorder of the prostate

*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 conditions** to it. If these apply to you they will be shown on your Policy Schedule.

Once you have held a Saga Health Insurance **policy** for two consecutive **years**, you may be able to claim for **treatment** of **pre-existing conditions** and **specified conditions** as long as you have had a **trouble free** period of two consecutive **years** for the **pre-existing condition** since your cover started.

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 Policy Schedule 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**:

(a) **Treatment** of a new **medical condition** that arises after you join.

(b) **Treatment** of **pre-existing conditions** and where applicable their **specified conditions** once you have held a Saga Health Insurance **policy** for at least two consecutive **years** and have had a consecutive two-year **trouble free** period.

5.2 What we do not pay for:

(a) **Treatment** of **pre-existing conditions** and **specified conditions** where that **pre-existing condition** is diabetes, raised blood pressure (hypertension) or you have been undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test for the first two **years** after you join.

(b) 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.

(c) **Treatment** of any other **medical condition** detailed on your Policy Schedule as excluded for benefit.

6 Your cover for certain types of treatment

What is eligible treatment?

Your **policy** covers **eligible treatment**. We consider **treatment** of a **medical condition** to be **eligible** when:

- the **treatment** falls within the benefits of your **policy** and is not excluded from cover by any term in this Policy Book.
- it is **treatment** of an **acute condition**
- it is **conventional treatment**
- it is not preventive **treatment**
- it does not cost more than an equivalent **treatment** that is as likely to deliver a similar therapeutic or diagnostic outcome
- it is not provided or used primarily for the convenience, financial or other advantage of you, your **specialist** or other health professional.

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 you have a **medical condition** when you have no symptoms or a genetic risk of developing or passing on a **medical condition**. Please call us before you have any genetic tests as the cost to you may be significant if the tests are not covered by your **policy**.

What other treatments are not covered?

There is no cover under this **policy** for **treatment** of mental health conditions. There are 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).

6.1 We pay for **eligible**:

(a) **Diagnostic tests** ordered by a **specialist** or **GP**.

(b) **Diagnostic tests** arranged by us when these tests are routinely required as part of your referral to a **specialist** to quickly and effectively diagnose or identify what **treatment** may be required.

(c) 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 our Claims Personal Advisory Team.

(d) Cash benefit towards dental and optical care, dental accident, dental emergency and a health assessment if you have chosen the optional Health Cash Benefits Cover, as shown in the **benefits table**.

(e) First 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; and
- we agree the cost of the **treatment** before it is done (see also 6.2(s)).

In the case of breast **cancer** the first reconstructive surgery means:
- One planned surgery to reconstruct the diseased breast
- One further planned surgery to the other breast, when it has not been operated on, to improve symmetry
- Up to two sessions of nipple tattooing.

(f) **Treatment** of varicose veins:
- One **surgical procedure** per leg for the lifetime of your **policy**, for example foam injection (sclerotherapy), ablation or other surgery
- One follow-up consultation with your **specialist**
- One simple injection to treat remaining or residual veins when it is carried out within 6 months of the main **surgical procedure**.

(g) Reasonable costs incurred for a live donor to donate an organ or tissue. If you plan to donate an organ or tissue as a live donor, or receive an organ or tissue from a live donor, please call our Claims Personal Advisory Team so we can tell you what support we can offer (see also 6.2(ff)).

(h) Up to £5,000 towards the cost of an **external prosthesis** needed following an accident or surgery for a **medical condition**, provided that:
- you had a Saga HealthPlan **policy** at the time of the accident or surgery that led to the need for a prosthesis and that you have had continuous cover with us ever since; and
- all claims are made within 12 months of the amputation or removal of the body part.

This benefit is payable once, regardless of how long you remain a **policyholder** with Saga. If you want to claim this benefit please call our Claims Personal Advisory Team so we can explain what to do next. Please remember to ask the provider of your **external prosthesis** for full receipts as we cannot pay claims without a receipt.

6.2 What we do not pay for:

(a) **Diagnostic tests** ordered by anyone other than a **specialist** or **GP**.

(b) Any dental procedure or orthodontics including referrals to dental specialists such as periodontists, endodontists, prosthodontists or orthodontists (except as allowed under Health Cash Benefits Cover, as shown in the **benefits table**, if you have chosen this optional cover).

(c) **Treatment** of thread veins or superficial veins.

(d) **Treatment** of symptoms generally associated with the natural process of ageing, including **treatment** for the symptoms of puberty and menopause.

(e) **Treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide.

(f) **Treatment** of, or **treatment** which arises from or is in any way connected with, alcohol abuse, drug abuse or substance abuse.

(g) Costs associated with the implementation of a mechanical heart pump (Ventricular Assist Device (VAD) or Artificial Hearts) or the device itself.

(h) **Treatment** which is not medically necessary or which may be considered a matter of personal choice.

(i) Any **treatment** of warts of the skin.

(j) Vaccinations, routine preventive examinations or preventive screening.

(k) Preventive **treatment**.

(l) Genetic screening tests to check whether:
- you have a **medical condition** when you have no symptoms

- you have a genetic risk of developing a **medical condition**
- there is a genetic risk of you passing on a **medical condition**.

(m) Genetic tests where the outcome of the test is not proven to change the course of **treatment**, for example if the course of **treatment** would be the same regardless of the **medical condition** that has caused your symptoms.

(n) Drugs, dressings or prescriptions that:
- you are given to take home following **in-patient**, **day-patient** or **out-patient treatment**; or
- could be prescribed by a **GP** or bought without a prescription; or
- are taken or administered when you attend a **hospital**, consulting room or clinic for **out-patient treatment**.

(o) Any costs incurred as a consequence of **treatment**, medical or surgical intervention or body modification that is not **eligible** under your **policy**, including increased **treatment** costs.

(p) The costs of providing or fitting any **external prosthesis** or appliance except as allowed in benefits 13 and 22(ii).

(q) The costs of any replacement teeth or hair, including wigs (except as allowed under 22(i)) or hair transplants.

(r) Charges for general chiropody or foot care (including but not limited to gait analysis and the provision of orthotics), even if this is carried out by a surgical podiatrist.

(s) Cosmetic (aesthetic) surgery or **treatment**, or any **treatment** relating to previous cosmetic or reconstructive **treatment**, including any cosmetic operation to a reconstructed breast (see also 6.1(e)).

(t) 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).

(u) Any **treatment** of refractive errors.

(v) Any **treatment** to correct long or short-sightedness.

(w) Costs incurred for, or related to, any kind of bariatric surgery, regardless of the reason the surgery is needed. This includes but is not limited to the fitting of a gastric band or creation of a gastric sleeve.

(x) **Treatment** relating to learning disorders, speech delay, educational problems, behavioural problems, physical development or psychological development, including assessment or grading of such problems. This includes, but is not limited to, problems such as dyslexia, dyspraxia, autistic spectrum disorder, attention deficit hyperactivity disorder (ADHD) and speech and language problems, including speech therapy needed because of another **medical condition**.

(y) 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**.

(z) Any **treatment** costs incurred as a result of your active involvement in criminal activity.

(aa) Any charges for primary care services, such as any services that would typically be carried out by a **GP** or dentist (except as allowed under Health Cash Benefits Cover, as shown in the **benefits table**, if you have chosen this optional cover).

(bb) 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.

(cc) **Treatment** of any mental health condition.

(dd) Any **treatment** costs incurred as a result of engaging in or training for any sport for which you receive a salary or monetary reimbursement, including grants or sponsorship (unless you receive travel costs only).

(ee) Claims on this **policy** if you live outside the **United Kingdom** or any **treatment** received outside the **United Kingdom**.

(ff) The cost of collecting donor organs or tissue or for any related administration costs (for example, the cost of a donor search) or for any costs towards organ or tissue donation that is not done in line with appropriate regulatory guidelines.

(gg) Any separate charge made by a **specialist** for consultations within 10 days after they have performed the **surgical procedure**.

(hh) Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6:

*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/six weeks of the **specialist** who would oversee the private **treatment** 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 unproven treatments?

Your **policy** covers you for **treatment** and **surgical procedures** that are **conventional treatments**.

We define **conventional treatment** as **treatment** that:
- is established as best medical practice and is practised widely within the **UK**; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the **treatment** is provided;

and has either:
- been shown to be safe and effective for the **treatment** of your **medical condition** through substantive peer-reviewed clinical trials in published authoritative medical journals; or
- been approved by NICE (The National Institute for Health and Care Excellence) as a **treatment** which may be used in routine practice.

Are there any additional requirements for drug treatments?

If the **treatment** is a drug, the drug must be:
- licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency; and
- used according to that licence.

Are there any additional requirements for surgical treatments?

If the **treatment** is a **surgical procedure** it must also be listed and identified in our technical document, called the Schedule of Procedures and Fees, which includes all the **surgical procedures** we pay benefits for. If you would like a copy of the Schedule of Procedures and Fees please contact our Claims Personal Advisory Team.

Your **policy** will also cover **unproven treatment** carried out by a **specialist**.

We define **unproven treatment** as:

- surgery not listed and identified in the Schedule of Procedures and Fees; and
- other **treatments** and **diagnostic tests** which are not **conventional treatments**.

If your **specialist** wants to carry out **treatment** that is not **conventional treatment**, it must be authorised by us before it takes place and it must take place in the **UK**. We will need to agree that the **unproven treatment** is a suitable equivalent to **conventional treatment**. If there is no suitable equivalent **conventional treatment**, there is no cover for the **unproven treatment**.

Are there restrictions on what you pay for unproven treatment?

The amount we pay for **unproven treatment** will depend on how much it costs and how much we would pay if you have **conventional treatment** for your **medical condition** instead.

- If the **unproven treatment** costs less than the equivalent **conventional treatment** we will pay the cost of the **unproven treatment**.
- If the **unproven treatment** costs more than the equivalent **conventional treatment** we will pay up to the cost we would have paid for the equivalent **conventional treatment**. We will pay up to the amount we would have paid a **fee-approved specialist** and **hospital** in the **Saga Countrywide Hospital List**. To understand what the equivalent **conventional treatment** is, we will look at the **treatment** other patients with the same **medical condition** and prognosis would be given.

Do I need to let you know if I want unproven treatment?

Yes, if you would like an **unproven treatment** you or your **specialist** must contact us at least 10 working days before you book that **treatment**. This is so we can:

- obtain full details of the **treatment**
- support you with additional information and questions for your **specialist**, before you have **treatment**
- agree what costs (if any) we will pay towards the **hospital**, **specialist**, anaesthetist and/or other provider. All **unproven treatment** must be agreed by us in writing, so you are clear how much we will pay towards your **treatment**.

We recommend you check with the **hospital**, **specialist**, anaesthetist and/or other provider how much they will charge for your **treatment** so you know how much you will be responsible for paying.

Will there be any restrictions on my cover after I have had unproven treatment?

Yes there will. We will not pay for further **treatment** for your **medical condition** after you have undergone **unproven treatment**. This includes any complications or other **medical conditions** associated with the **unproven treatment**.

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 it is important to call our Claims Personal Advisory Team so we can confirm the extent of the cover we will provide before you undertake any **treatment**.

6.3 We pay for **eligible**:

(a) Additional costs incurred for the **treatment** of **medical conditions** when they occur during 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**.

6.4 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 miscarriage and assisted reproduction, or any consequence of any of the above or any **treatment** for them, except as shown in 6.3(a) above.

(c) Investigations into and **treatment** of infertility, or **treatment** designed to increase fertility (including **treatment** to prevent future miscarriage).

(d) Contraception or sterilisation (or its reversal) or any consequence of any of them or of any **treatment** for them.

(e) **Treatment** of or related to sexual dysfunction or any consequence of it.

(f) 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.

(g) Any **treatment** for a baby born after taking any prescription or non-prescription drug or other **treatment** to increase fertility, or as the result of any method of assisted conception such as IVF, while the baby requires **treatment** in a Special Care Baby Unit or requires paediatric intensive care.

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, check-ups and examinations) will not be covered under your **policy**. We will advise you 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 part of **treatment** of an **acute condition** that is covered by your **policy**; and:

- it follows an acute brain injury, such as a stroke; and
- it is carried out by a **specialist** in rehabilitation; and
- it is carried out in a recognised rehabilitation **hospital** or unit which is either listed in the **Saga Countrywide Hospital List** or which we have written to confirming it is recognised by us; and
- it could not be carried out on a **day-patient** or **out-patient** basis or in another appropriate setting; and
- 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) 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 section 5 'Existing medical conditions' for further information on your cover for pre-existing **medical conditions**.

Your **policy** covers the investigation and **active treatment of cancer**. This includes surgery, radiotherapy or chemotherapy, alone or in combination.

If you do not have Extended Cancer Cover: 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.

Your **policy** covers you for a **nurse** to give you chemotherapy by intravenous drip at home or somewhere else that is appropriate as long as:

- we have agreed the **treatment** beforehand;
- you would otherwise need to be admitted for **in-patient** or **day-patient treatment**;
- the **nurse** is working under the supervision of a **fee-approved specialist**; and
- the **treatment** is provided through a healthcare services supplier that we have a contract with for this kind of service.

*If you have Saga HealthPlan Saver Plus 4 or Saga HealthPlan Saver Plus 6 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/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed.*

Please note:

If you have Extended Cancer Cover (this will be shown on your Policy Schedule) the table shown in this section on pages 21-22 is replaced. Please refer to pages 23-25 for the new table showing details of your extended cover for **cancer**.

NHS or private?

Whilst you are covered for **eligible active treatment of cancer** on this **policy** you may decide that you want to receive **treatment** on the NHS.

If you are diagnosed with **cancer** you will be referred to one of our specialist nurses in our Cancer Care team. They will be able to give you information on the **treatment** options open to you and support you through your **treatment**.

If you receive your **treatment** as an NHS patient you will be able to claim the NHS hospital cash benefit shown in the **benefits table**, when you receive **eligible in-patient treatment**.

If your **treatment** would be **eligible** under your **policy** as a private patient, but after discussion with our specialist nurses you choose to have NHS **treatment** instead, our specialist nurses can also offer other services to support you whilst you are receiving NHS **cancer treatment**, for example domestic help or assistance with travel costs to and from the hospital.

The following table is a summary of the cover provided for **cancer** under this **policy** and should be read alongside the rest of the Policy Book, including the **benefits table**.

	Cover	
Where am I covered for treatment?	✓	**Active treatment of cancer** at any **hospital** listed in the **Saga Countrywide Hospital List** or, if you have chosen Fixed Fast Track, a **hospital** we have chosen with you.
	✗	Charges made for the **treatment** of **cancer** at any hospital not listed in the **Saga Countrywide Hospital List** or, if you have chosen Fixed Fast Track, a hospital we have not chosen with you.
	✓	Home nursing received at home in the circumstances shown in the **benefits table**.
	✓	Chemotherapy by intravenous drip at home. Please refer to 'Your cover for cancer treatment' on page 20 for more information.
	✗	**Treatment** received at a hospice.
What cover do I have for diagnostic tests/ procedures?	✓	Consultations with a **specialist** treating your **cancer**, **diagnostic tests** ordered by a **GP** or a **specialist** treating your **cancer**, CT, MRI and PET scans ordered by a **specialist** treating your **cancer** and **surgical procedures**. If any of these take place before a diagnosis of **cancer**, the costs will be subject to any **out-patient** benefit limits.
	✗	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 page 17, when that **treatment** has been established as being effective.
	Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6	*At the time of going to print the NHS was commonly providing **treatment** of **cancer** within four/six weeks and therefore it is unlikely that there will be cover on these **policies** for such surgical **treatment**.*
Am I covered for preventive treatment?	✗	Preventive **treatment**, for example: • 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**.

	Cover	
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 **treatment** 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). **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 our Claims Personal Advisory Team once you know your **treatment** plan. These drug **treatments** will be covered for up to: • 18 months of such **treatment**; or • the period of the drug licence whichever is the shorter. The time limit starts from when you first started receiving the drug **treatment** funded by us and does not get reset if the type of drug you are receiving changes during the course of **cancer treatment**. 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**. Within these time limits there is also cover for antivirals, antibiotics, antifungals, anti-sickness and anticoagulant drugs while you are undergoing **eligible** chemotherapy for **cancer**.
	✗	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** or that could be bought over the counter are not covered by your **policy**. This includes any take-home drugs or prescriptions you are given following **in-patient**, **day-patient** or **out-patient treatment**. For example, hormone therapy tablets (such as Tamoxifen) are **out-patient** drugs and therefore are not covered by our policies.
Am I covered for radiotherapy?	✓	Radiotherapy, including when used to relieve pain.
Am I covered for proton beam therapy (PBT)?	✓	We will pay for PBT for: • central nervous system (brain and spinal cord) **cancer** or malignant solid **cancers** in **family members** aged 21 and under; • chordomas or chondrosarcomas (types of spine **cancer**) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised); • **cancer** of the iris, ciliary body or choroid parts of the eye (uveal melanoma) which has not spread (metastasised).
Am I covered for accelerated charged particle therapies?	✗	There is no cover for accelerated charged particle therapies. However, there is limited cover for proton beam therapy in the circumstances shown above.
Am I covered for terminal care?	✗	There is no cover for terminal care, wherever carried out.
Am I covered for monitoring?	✓	Follow-up consultations and reviews of **cancer** will be covered as long as you remain a Saga HealthPlan **policyholder**, subject to the terms and conditions of that policy at the time. **Please note:** We will not pay for routine checks that could typically be carried out by your **GP**. These will not affect your **out-patient** benefit limits. *Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: Some **cancer** patients may need follow-up procedures such as colonoscopies or cystoscopies, which are needed not in order to provide **treatment** but to monitor the patient as part of the planned management. These procedures can be scheduled in advance on the NHS for whenever they are needed and are not covered by these **policies**, as they would be available under the NHS within four/six weeks from the date on which they should take place.*
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 'Your cover for certain types of treatment'.
	✗	Any related administration costs (such as, but not limited to, transport costs and the cost of a donor search).

Extended Cancer Cover

Additional cover for cancer treatment

The 'Your cover for cancer treatment' section contains information on the standard cover for **cancer treatment**.

If you have Extended Cancer Cover, you also have extended cover for some **treatments** for **cancer** including benefit for the purchase of wigs and the provision of external prostheses while you are undergoing **active treatment of cancer**. This benefit is available regardless of whether you are having your **cancer treatment** on the NHS or as a private patient.

The hospital expenses cash benefit is paid out in full once a diagnosis of **cancer** has been made and, for example, can be used towards hospital car parking. Please see the **benefits table** on page 8 for more information.

The table below replaces the table shown on pages 21-22.

Summary of Extended Cancer Cover

	Cover	
Where am I covered for treatment?	✓	**Active treatment of cancer** at any **hospital** listed in the **Saga Countrywide Hospital List** or, if you have chosen Fixed Fast Track, a **hospital** we have chosen with you.
	✗	Charges made for the **treatment** of **cancer** at any hospital not listed in the **Saga Countrywide Hospital List** or, if you have chosen Fixed Fast Track, a hospital we have not chosen with you.
	✓	Home nursing received at home in the circumstances shown in the **benefits table**.
	✓	Chemotherapy by intravenous drip at home. Please refer to 'Your cover for cancer treatment' on page 20 for more information.
	✓	There is a charitable donation payable for each night spent in a hospice or for each night you are receiving hospice at home.
What cover do I have for diagnostic tests/procedures?	✓	Consultations with your **cancer**-treating **specialist** (such as an oncologist, surgeon, radiotherapist or haematologist), **diagnostic tests** ordered by a **GP** or your **cancer**-treating **specialist**, including CT, MRI and PET scans and **surgical procedures**. If any of these take place before a diagnosis of **cancer**, the costs will be subject to any **out-patient** benefit limits.
	✓	Cover for genetic testing proven to help the selection of appropriate chemotherapy.
	✗	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 page 17, when that **treatment** has been established as being effective.
	Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6	*At the time of going to print the NHS was commonly providing **treatment** of **cancer** within four/six weeks and therefore it is unlikely that there will be cover on these **policies** for such surgical **treatment**.*
Am I covered for preventive treatment?	✗	Preventive **treatment**, for example: • 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**.

	Cover	
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 **treatment** 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). These drug **treatments** will be **eligible** for benefit when they are used within the terms of their licence and up to the period of the drug licence. **Please note:** changes in drug licensing mean that **cancer** drug **treatments** covered under this **policy** will change from time to time. For further information on licensed **cancer treatment** please contact our Claims Personal Advisory Team once you know your **treatment** plan.
	✓	Unproven drug **treatments** for **cancer** will be covered when you have been invited to be a participant in a randomised clinical trial which has been approved by the appropriate ethics committee. We will pay for your stay in **hospital**, including your **specialist's** fees while you are receiving the clinical drug trial. The cover and costs must be agreed by us in writing before **treatment** commences.
	✓	Cover for chemotherapy and/or biological 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. Cover for bisphosphonates used to prevent bone damage in **cancer** when they are administered alongside **eligible** chemotherapy for **cancer**. In addition we will cover the cost of injectable hormone **treatment** used to manage your **cancer** whilst you are undergoing **eligible** chemotherapy for **cancer**. There are also some drugs given to treat conditions secondary to **cancer**, such as erythropoietin (EPO), which will be covered whilst you are undergoing **eligible** chemotherapy for **cancer**. There is also cover for antivirals, antibiotics, antifungals, anti-sickness and anticoagulant drugs while you are undergoing **eligible** chemotherapy for **cancer**. **Please note:** changes in drug licensing mean that **cancer** drug **treatments** covered under this **policy** will change from time to time. For further information on licensed **cancer treatment**, please contact our Claims Personal Advisory Team once you know your **treatment** plan.
	✗	**Out-patient** drugs and/or drugs prescribed by your **GP** or that could be bought over the counter are not covered by your **policy**. This includes any take-home drugs or prescriptions you are given following **in-patient**, **day-patient** or **out-patient treatment**. For example, hormone therapy tablets (such as Tamoxifen) and bisphosphonates that are not administered alongside **eligible** chemotherapy for **cancer** would not be covered by our policies.
Am I covered for radiotherapy?	✓	Radiotherapy, including when used to relieve pain.
Am I covered for proton beam therapy (PBT)?	✓	We will pay for PBT for: • central nervous system (brain and spinal cord) **cancer** or malignant solid **cancers** in **family members** aged 21 and under; • chordomas or chondrosarcomas (types of spine **cancer**) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised); • **cancer** of the iris, ciliary body or choroid parts of the eye (uveal melanoma) which has not spread (metastasised).
Am I covered for accelerated charged particle therapies?	✗	There is no cover for accelerated charged particle therapies. However, there is limited cover for proton beam therapy in the circumstances shown above.
Am I covered for palliative or end of life care?	✓	**Active treatment of cancer** needed regardless of whether the intention of this **treatment** is to cure.
	✓	Secondary **surgical procedures** needed to relieve symptoms as a direct result of **cancer**, such as the insertion of a stent or draining of fluid.
	✓	We will make a charitable donation if you are being cared for in the end stages of life at a hospice or if you are receiving hospice at home.

	Cover	
Am I covered for monitoring?	✓	Follow-up consultations and reviews of **cancer** will be covered as long as you remain a Saga HealthPlan **policyholder** with an appropriate cancer benefit. Cover will be subject to the **policy** terms and conditions at that time. **Please note:** We will not pay for routine checks that could typically be carried out by your **GP**. These will not affect your **out-patient** benefit limits. *Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: Some **cancer** patients may need follow-up procedures such as colonoscopies or cystoscopies, which are needed not in order to provide **treatment** but to monitor the patient as part of the planned management. These procedures can be scheduled in advance on the NHS for whenever they are needed and are not covered by these **policies**, as they would be available under the NHS within four/six weeks from the date on which they should take place.*
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 'Your cover for certain types of treatment'.
	✗	Any related administration costs (such as, but not limited to, transport costs and the cost of a donor search).

8 Who we pay for treatment and where you can be treated

If you have chosen the Saga Countrywide Hospital List or our London Upgrade, or you live in the Channel Islands or Isle of Man, the following information applies:

(If you have chosen Fixed Fast Track, please see page 28.)

You need to call us before receiving any **treatment**. This will allow us to review our records to check or identify someone to treat you who is **eligible** for benefit and confirm that the place where **treatment** is being carried out is also covered.

In addition to the explanation throughout this section, the table below shows which services are **eligible** for benefit and who can refer you for **treatment**.

We will pay charges for **eligible treatment** from:	If you are referred by your **GP**	If you are referred by a **specialist**	If you are referred by your dentist
Specialists*	✓	✓	✓
Practitioners	✓	✓	✗
Therapists, **homeopaths** and **acupuncturists**	✓	✓	✗
Physiotherapists	✓	✓	✗

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

Your **GP** may have made an **open referral**, stating what **treatment** is necessary and the type of **specialist** you require that **treatment** from, but not specifying the **specialist's** name. If this is the case we can support you in identifying a suitable **specialist** and, in many cases, we can also book your appointment with the **specialist** for you.

What services under the direction of a fee-approved specialist are eligible for benefit?

We pay **eligible treatment** charges made by a **fee-approved specialist** for consultations, **diagnostic tests**, **treatment** in **hospital** and **surgical procedures** when you are referred for **specialist treatment** in that medical specialty by your **GP**, **specialist** or dentist, subject to any **out-patient** benefit limits.

You can be reassured that the vast majority of **specialists** we recognise are **fee-approved specialists**, so please contact us before receiving any **treatment** and we will help identify a **fee-approved specialist** to treat you.

What services under the direction of a fee-limited specialist are eligible for benefit?

If you have **eligible treatment** with a **fee-limited specialist** we will only pay up to the amount shown within the Schedule of Procedures and Fees towards their personal charges. If you would like a copy of the Schedule of Procedures and Fees, please contact our Claims Personal Advisory Team.

If you receive **treatment** with a **fee-limited specialist** you are likely to need to make a contribution to the fees charged by that **specialist**.

Be aware:

There are some medical providers who we do not recognise at all. If you receive **treatment** from one of these medical providers we will not pay those fees or any other fees for **treatment** costs under the direction of that provider.

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 a **fee-approved specialist**. 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. If you choose to receive **treatment** with an anaesthetist who is a **fee-limited specialist**, we will pay up to the amount shown within the Schedule of Procedures and Fees towards the charges for their services.

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 before the **treatment** begins, then we will pay those hospital charges.

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

If you have **in-patient treatment**, **day-patient treatment**, computerised tomography (CT) or magnetic resonance imaging (MRI) scans, or 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 as shown under 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, subject to the terms of your **policy**, if you use a **scanning centre** listed 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).

What services provided by a recognised therapist or physiotherapist are eligible for benefit?

Cover is available for **eligible treatment** with a **therapist** or **physiotherapist** when you are referred by the Working Body team, your **GP** or a **specialist**, subject to any excess or **out-patient** benefit limits.

We recognise a large number of **therapists** and **physiotherapists** in the **UK**. We have identified which **therapists** and **physiotherapists** for whom we pay **eligible treatment** fees in full when you are under the direction of a **specialist**. Please contact us before receiving any **treatment** and we will help identify a **therapist** or **physiotherapist** we recognise.

If you choose to receive **treatment** from a **therapist** or **physiotherapist** who we do not recognise, there will be no cover for the cost of their charges.

What services provided by a recognised practitioner, acupuncturist or homeopath are eligible for benefit?

We will pay **eligible treatment** fees in full when an **acupuncturist**, **homeopath** or **practitioner** charges up to the level shown within the Schedule of Procedures and Fees when you are referred by your **GP** or a **specialist**, subject to any excess or **out-patient** benefit limits. If you would like a copy of the Schedule of Procedures and Fees, please contact our Claims Personal Advisory Team.

8.1 We pay for **eligible**:

(a) **Treatment** charges made by a **nurse** for nursing at home benefit detailed in the **benefits table**.

(b) Saga HealthPlan Saver Plus:

*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**.)*

(c) 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) Charges made by a **specialist**, **therapist**, **physiotherapist**, **acupuncturist** or **homeopath** when you have been referred to them by a member of your family, or if that **specialist**, **therapist, physiotherapist**, **acupuncturist** or **homeopath** is a member of your family.

(b) **Treatment** charges made by a **fee-approved specialist** or **therapist** 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**.

(c) Any charges from health hydros, spas, nature cure clinics or any similar place, even if it is registered as a hospital.

(d) Special nursing in hospital unless we have agreed beforehand that it is necessary and appropriate.

(e) Any charges made by, or incurred in, an NHS hospital for ITU **treatment**, except as allowed for by 8.1(b).

(f) Any charges made for written reports or any administrative costs, apart from charges made by a **GP** to complete your claim form, which we do pay for.

Where can I find more information about the quality and cost of private treatment?

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

If you have chosen Fixed Fast Track (not available if you live in the Channel Islands or Isle of Man) the following information applies:

(If you have chosen the Saga Countrywide Hospital List or our London Upgrade, or you live in the Channel Islands or Isle of Man, please see pages 26-27.)

You need to contact us before making any appointments so we can understand your **treatment** requirements and help you choose a **selected provider** to receive your **treatment** with.

What happens on Fixed Fast Track if I do not call the Claims Personal Advisory Team prior to my treatment?

If you do not contact us to authorise **treatment** with a **selected provider** we will not pay for the **treatment** you receive and you will be liable for the cost of **treatment**.

If you have **eligible in-patient treatment** as a National Health Service (NHS) patient incurring no charges at all, then we will pay any NHS cash benefit shown in the **benefits table**.

What services under the direction of a specialist are eligible for benefit with Fixed Fast Track?

We pay **eligible treatment** charges made by a **specialist** for consultations, **diagnostic tests**, **treatment** and **surgical procedures** when **treatment** is received at a **hospital**, **day-patient unit**, **scanning centre** or **out-patient facility** that we have helped you choose, following a referral to that type of **specialist** by your **GP**.

Will treatment charges be met in full with Fixed Fast Track?

When you receive **eligible treatment** from a **selected provider**, we can normally meet the **treatment** charges in full, subject to any excess and specific benefit limits of this **policy**. There may be rare occasions when we will not be able to pay a **selected provider's** fees in full and if this is the case we will let you know when you call us to pre-authorise your **treatment**. This is why it is important you call us each time you need any **treatment**, as on these rare occasions we can support you in finding a **selected provider** whose **treatment** charges can be met in full.

What services provided by a recognised therapist or physiotherapist are eligible for benefit with Fixed Fast Track?

Cover is available for **eligible treatment** with a **therapist** or **physiotherapist** that we have helped you choose when you are referred by the Working Body team, your **GP** or a **specialist**, subject to any excess or **out-patient** benefit limits.

We recognise a large number of **therapists** and **physiotherapists** in the **UK**. We have identified those **therapists** and **physiotherapists** for whom we pay **eligible treatment** fees in full when you are under the direction of a **specialist** and, after discussing your **treatment** requirements with you, we will help you choose one of them to receive your **treatment**.

If you decide to receive **treatment** from a **therapist** or **physiotherapist** not chosen by us, there will be no cover for the cost of their charges.

What services provided by a recognised practitioner, acupuncturist or homeopath are eligible for benefit with Fixed Fast Track?

We will pay **eligible treatment** fees when you use an **acupuncturist**, **homeopath** or **practitioner** we have chosen for you when you are referred by your **GP** or a **specialist**, subject to any excess or **out-patient** benefit limits. If you decide to receive **treatment** from an **acupuncturist**, **homeopath** or **practitioner** not chosen by us, there will be no cover for the cost of their charges.

8.3 With Fixed Fast Track we pay for **eligible**:

(a) **Treatment** charges made by a **nurse** for nursing at home benefit detailed in the **benefits table**.

(b) Saga HealthPlan Saver Plus:

*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**.)*

(c) 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.

8.4 With Fixed Fast Track we do not pay for:

(a) **Treatment** which is not received from, or under the control of, a **selected provider**.

(b) **Treatment** received from a **selected provider** that we did not choose for you.

(c) Any charges from health hydros, spas, nature cure clinics or any similar place, even if it is registered as a hospital.

(d) Special nursing in hospital unless we have agreed beforehand that it is necessary and appropriate.

(e) Any charges made by, or incurred in, an NHS hospital for ITU **treatment**, except as allowed for by 8.3(b).

(f) Any charges made for written reports or any administrative costs, apart from charges made by a **GP** to complete your claim form which we do pay for.

Where can I find more information about the quality and cost of private treatment?

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

9 Health Cash Benefits Cover

In addition to the cover on your **policy** shown in section 6 'Your cover for certain types of treatment', you may have also selected Health Cash Benefits Cover. The Health Cash Benefits Cover provides cash back towards the cost of dental care, optical care, dental accident, dental emergency and a health assessment, as shown below.

There is no waiting period for pre-existing conditions so section 5 'Existing medical conditions' does not apply to Health Cash Benefits Cover.

We will not pay for dental **treatment**, which to the best of your knowledge and belief you were aware was needed before you joined this **policy**. We may request additional information from you as part of your claim.

We will reimburse you towards the cost of **treatment** under each benefit limit up to the maximum amounts payable for each person covered per **year** as stated in your **benefits table**.

Please note: these benefits are not available to any children included under the **policy** – they are available to the **policyholder** and their spouse/partner only (for a definition of spouse or partner, please refer to '**family member**' in the 'Glossary' section).

Dental care

9.1 We pay for **eligible** cash benefit in line with the **benefits table** up to the maximum benefit per person a **year** towards:

(a) Dental **treatment**.
(b) Dental examination.
(c) Dentures.

9.2 We do not pay the cash benefit for:

(a) Veneers, bleaching or other tooth whitening.
(b) Prescription charges.
(c) Denture repairs.
(d) Consumables such as mouthguards and toothbrushes.
(e) Premiums in respect of any form of dental insurance/ contract scheme or dental admin fees.

Optical care

9.3 We pay for **eligible** cash benefit in line with the **benefits table** up to the maximum benefit per person a **year** towards:

(a) Eyesight tests, prescribed spectacles, lenses or contact lenses paid for by the **policyholder** or spouse/ partner, where payment has been made to a qualified optician who is registered with the General Optical Council.
(b) Laser eye surgery received at a registered laser eye clinic.

9.4 We do not pay the cash benefit for:

(a) Frames only, repairs, cleaning solutions, and other optical care items.
(b) Cataract surgery (although you may be able to claim for this condition using your other Saga HealthPlan benefits, so please call us to check).
(c) Lenses or spectacles purchased under an optical care insurance policy/contract scheme.
(d) Sunglasses that are not prescription sunglasses.
(e) Any other optical specialist.

Dental accident

9.5 We pay for **eligible** cash benefit in line with the **benefits table** up to the maximum benefit per person a **year** towards:

(a) Dental **treatment** needed due to injury to the teeth or supporting structures (including damage to dentures while being worn) caused suddenly and unexpectedly by means of direct external impact.

9.6 We do not pay the cash benefit for:

(a) Repair or replacement bridges, crowns, or dentures unless damaged as described in 9.5(a) above.
(b) Damage to dentures except while being worn.
(c) Any injury caused by eating and/or drinking.
(d) Sporting injuries where a mouthguard or other recommended protection is not worn.
(e) Normal wear and tear.

Dental emergency

9.7 We pay for **eligible** cash benefit in line with the **benefits table** up to the maximum benefit per person a **year** towards:

(a) Dental **treatment** provided at the initial emergency appointment urgently required for the relief of significant pain, arrest of haemorrhage, management of acute infection or a condition which causes a severe threat to your general health.

9.8 We do not pay the cash benefit for:

(a) Any follow-up dental appointments or **treatment** required after the initial dental emergency visit – these would need to be claimed for under the benefit for dental care up to the maximum amounts payable under that benefit.
(b) Denture repairs.
(c) Prescription charges.
(d) Normal wear and tear.

Health assessment

9.9 We pay for **eligible** cash benefit in line with the **benefits table** up to the maximum benefit per person a **year** towards:

(a) A health assessment when it takes place at a screening facility in a registered **hospital** or in a mobile screening facility under contract with a registered **hospital** by medically qualified staff.

9.10 We do not pay the cash benefit for:

(a) Health assessments other than as stated in 9.9(a) (including tests completed at a retail outlet or health club).

(b) Tests which have been received in order to further legal/industrial action related to employment or emigration or as part of a pension scheme or insurance claim.

How to make a claim against the benefits of your Health Cash Benefits Cover

To ensure your Health Cash Benefits Cover claim proceeds smoothly, please follow these simple steps

Step One	Arrange for a Health Cash Benefits Cover claim form to be completed and send it to us with the original receipted account(s) showing a full description and date of the consultation, **treatment** or service provided, and the name of the person the charges apply to. If you do not have a claim form, you can print one from our website at saga.co.uk/health-insurance, alternatively please request one by calling our Claims Personal Advisory Team on **0800 027 1331** (Monday to Friday 8am-8pm, Saturday 9am-5pm).
Step Two	The claim form should be received by us within 13 weeks of: • the date on the original receipted account for consultation and associated charges; or • the date on the original receipted account for charges made (where such **treatment** continues over an extended period, claims need to be submitted periodically, at intervals not exceeding 13 weeks).
Step Three	Once we have received your completed claim form we will assess the claim and reimburse you by cheque up to the maximum amount payable as stated in the **benefits table**.

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

10 Additional information

When can I add other family 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 0800 056 9273 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, or adopted by, 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 'Existing medical conditions') 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 after taking any prescription or non-prescription drug or other **treatment** to increase fertility, or as the result of any method of assisted conception such as IVF. 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 in which to cancel your **policy** and receive a refund of your premium provided no claims have been made. Cancellations after the 14 day cooling-off period may not result in a refund of your premium. Please see 12.1(g) and 12.1(h) in the section 'Complaint and regulatory information'.

How can I pay my premium?

This **policy** lasts for one **year** and 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. 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 and each annual premium payment is for one **year's** cover. If you pay monthly, each premium payment is for one month's cover.

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.

Please note that if you amend or cancel your **policy** during the **policy year** and have paid by credit card or cheque, we will be unable to refund any amounts of £5 or less. Similarly, if you make any changes to your **policy** during the **policy year**, we will only request any charges from you if the amount is over £5.

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 Policy Schedule, this means that in any NCD year:

Where nobody covered on the **policy** makes a claim	The NCD for the **policy** is increased by one level at the following **policy** renewal date until level 10 is reached.
For each claim made on the **policy**	The NCD for the **policy** is reduced by two levels at the following **policy** renewal date for each claim made until level 0 is reached.

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?

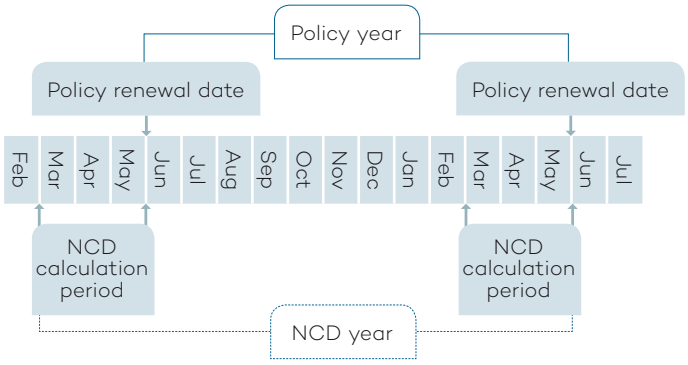
- We will consider any **treatment** for the same **medical condition**, received within 12 months of the date that **treatment** first started, as one single claim;
- For the purposes of the NCD a claim is any amount of money we pay for providing **treatment** for one **medical condition**, no matter how small or how many **eligible** consultations, tests, scans or other surgical or medical services form part of the **treatment**;
- The NCD will not be affected by the following:
  - Claims paid for NHS cash benefit;
  - Claims under the **external prosthesis** benefit;
  - Claims for **eligible treatment** with a **therapist**, **homeopath**, **acupuncturist** or **physiotherapist**;
  - Claims under the optional Health Cash Benefits Cover;
  - Claims under the optional Extended Cancer Cover for hospital expenses, purchase of wigs or hospice donation;

  Please note: While the **treatments** listed above do not affect your NCD, if you should claim additional **treatments**, for example a consultation with a **specialist** prior to your physiotherapy, your NCD will be affected.
- The claim is recorded based on the date the **treatment** is received.

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 Policy Schedule 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 Policy Schedule 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 0800 056 9273.

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 £1,000 (for each person each **year**) for **out-patient** consultations, **diagnostic tests** and **practitioner**, **therapist**, **physiotherapist**, **acupuncturist** and **homeopath** charges.

Example 1	
One	You develop a medical problem and require £600 of **eligible diagnostic tests** – your first claim for that **policy year**.
Two	The £100 excess charge is applied.
Three	We pay £500 towards the £600 cost of **out-patient treatment**, while you pay the £100 excess.
Four	This £600 total claim reduces your £1,000 benefit limit for **out-patient** consultations, **diagnostic tests** and **practitioner**, **therapist**, **physiotherapist**, **acupuncturist** and **homeopath** charges to £400.
Then...	Later in the same **policy year**, you suffer a different **medical condition**, incurring costs of £450 for **eligible out-patient** consultations and **diagnostic tests** – £50 more than the **policy's** remaining £400 benefit limit.
So...	We pay £400 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 £1,200 of **eligible diagnostic tests** but the **policy** limit is £1,000.
Two	So, we pay £1,000 for the **treatment** – less the £100 excess – giving a total of £900.
Three	You pay the remaining £200 not covered by the **policy** plus the £100 excess making a total of £300.
So...	Leaving no further benefit for **out-patient** consultations, **diagnostic tests** or **practitioner**, **therapist**, **physiotherapist**, **acupuncturist** and **homeopath** charges for the rest of the **policy year**.

11 Advice and support lines

Saga GP Service

Some GP surgeries are unable to provide appointments immediately or at a time which fits in with busy lives. Maybe it's difficult to get to the surgery during their opening hours or perhaps appointments are not readily available for several days, causing an unwanted delay. If this is the case for you, then you may find that the Saga GP Service can help.

The Saga GP Service is available 24 hours a day, 365 days a year and allows you to speak, in confidence, with a qualified, practising GP at a time convenient for you. You may call as often as you need, knowing that the information you receive is given by GPs who are in touch with the latest advances in medical care.

There are many things that the doctors are able to talk to you about. Some of them are:

- Your symptoms – a persistent ache or pain – giving you advice and discussing possible treatments
- Explanations of diagnosis or treatment that you may already have been prescribed
- Sensitive or confidential concerns
- Side effects of any medication you are taking
- Possible after-effects of surgery
- Vaccinations you may need when you're travelling abroad and other health precautions relevant to your own medical history.

Your call will be answered by a specially trained operator. The operator will take some details from you and arrange for a GP to call you back at a convenient time.

Many callers find that they receive the advice, reassurance and, where appropriate, the diagnosis they need from the Saga GP Service without having to go to their own GP. The service is completely confidential. However, in some cases the doctor may think it is advisable, and subject to your agreement, that a record of your consultation is sent to your own NHS GP, in order to keep him/her informed, also allowing your NHS records to be updated.

The doctors on the Saga GP Service can give advice, but if you have symptoms, which mean that you need a physical examination, or you need a prescription, then you may need to see a GP in person.

Saga GP Service – 0800 027 1333

Saga GP Service is available to you any time – day or night, 365 days a year.

If calling from outside the UK, phone +44 800 027 1333 – international call rates apply.

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

Please note:

In an emergency situation, you should contact your own NHS GP or the emergency services directly so as not to delay the appropriate treatment.

Access to the Saga GP Service is provided in addition to your policy. This service is provided to you by a third party, Medical Solutions UK Limited, whose registered address is 10 Upper Berkeley Street, London W1H 7PE.

Saga Health Information Line

With 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 because you have concerns about an ongoing medical condition that you would like to discuss; or maybe you have some questions following a consultation that you did not think to ask at the time, then it's likely that the Saga Health Information Line will be able to provide you with 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 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, phone +44 800 17 40 17 – international call rates apply.

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

Please note:

The Saga Health Information Line can provide you with valuable information to help put your mind at rest. It does not diagnose or prescribe and is not designed to take the place of your GP.

As the Saga Health Information Line and the Saga GP Service are confidential services, any information you discuss is not shared with our Claims Personal Advisory Team.

If you wish to authorise treatment or enquire about a claim, our Claims Personal Advisory Team will be happy to help you.

12 Complaint and regulatory information

Not happy with our service?

The most important thing for us is to help resolve your concerns as quickly and easily as possible. We'll do all we can to resolve your complaint by the end of the next business day. However, if we can't do this, we'll contact you within five working days to acknowledge your complaint and explain the next steps. Letting us know you're unhappy with our service gives us the opportunity to put things right for you and improve our service for everybody.

No matter how you decide to communicate your concerns, we'll listen.

To help us resolve your complaint, we'll need the following:

- Your name and **policy** details
- A contact telephone number
- A description of your complaint
- Any relevant information relating to your complaint that we may not have already seen.

For queries and complaints not related to a claim

If you have a query or complaint about private health insurance that is not regarding a claim, you can call us on: 0800 056 9273 or write to us at:

The Customer Relations Department
Saga Services Limited
Middelburg Square
Folkestone CT20 1AZ

Fax: 01303 771347 or
Email: services.customer-relations@saga.co.uk

For queries and complaints related to a claim

If you have a complaint about a private health insurance claim, you can call us on: 0800 027 1331 or write to us at:

AXA PPP healthcare
Phillips House
Crescent Road
Tunbridge Wells TN1 2PL

Financial Ombudsman Service

We will generally issue our final response within eight weeks from when you originally contacted us. However, we will respond sooner than this if we are able.

If it looks as though our review of your complaint will take longer than this, we will let you know the reasons for the delay and will keep you updated.

You may be entitled to refer your complaint to the Financial Ombudsman Service. The ombudsman service can liaise with us directly about your complaint and if we cannot fully respond to a complaint within eight weeks or if you are unhappy with our final response, you can ask the Financial Ombudsman Service for an independent review.

How to contact the Financial Ombudsman Service

Financial Ombudsman Service
Exchange Tower
Harbour Exchange Square
London E14 9SR
By telephone: 0800 023 4567 or 0300 123 9123
Email: complaint.info@financial-ombudsman.org.uk
Website: financial-ombudsman.org.uk

None of these procedures affect your legal rights.

What regulatory protection do I have?

The Financial Conduct Authority

Saga Services Limited is regulated and authorised by the Financial Conduct Authority (FCA). AXA PPP healthcare is regulated by the FCA and also regulated and authorised by the Prudential Regulation Authority (PRA). The FCA have 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 register number is 202947.
This information can be checked on the FCA website: register.fca.org.uk or by calling 0800 111 6768.

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). The scheme 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: fscs.org.uk

What we do with your personal data

Here is a summary of the data privacy notices that you can find on our websites at: saga.co.uk/privacy-policy.aspx and axappphealthcare.co.uk/privacynotice.

Please make sure that everyone covered by this **policy** reads this summary and the full data privacy notices on our websites. If you would like a copy of either of our full notices call us on the contact numbers contained in this Policy Book and we'll send you one.

We want to reassure you we never sell your personal information to third parties. We will only use your information in ways we are allowed to by law, which includes collecting only as much information as we need. We will get your consent to process information such as your medical information when it's necessary to do so.

Where use of your information by us relies on your consent you can withdraw your consent, but if you do we may not be able to process your claims or manage your **policy** properly.

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 Health Insurance **policy**, and when a claim is made. This may include medical information we obtain from medical practitioners and other health consultants. We may also obtain information from third party suppliers of information such as credit reference agencies.

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 audit, 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, to maintain management information for business analysis, for research and to find out more about you. They will disclose your information, including your health information, to Saga only to the extent necessary for the purposes of audit, managing your **policy** and claims. Saga may also use the health information shared with them for other purposes but they will only do so in line with data protection legislation.

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 AXA PPP healthcare may also disclose information to a representative you/your named **family member** have chosen.

The fact that a **family member** has claimed (but not the full details of the claim) may be disclosed to the **policyholder** in order for Saga to properly manage the **policy**. For example to provide the correct No Claim Discount. If an endorsement is added to the **policy** at any stage which excludes **treatment** of a specific condition, then this information will be available to the **policyholder** regardless of which insured **family member** the exclusion relates to.

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. We may, at our discretion, appoint third parties to service the **policy** and claims, including other companies based outside the European Economic Area, and which may be in a country that does not offer the same level of data protection as within the European Economic Area. We will always use every reasonable effort to ensure sufficient protections are in place to safeguard your personal information.

Marketing policy

Saga may share your personal information, and your medical data, with other Saga Group (Saga plc and its subsidiaries) companies. Saga uses the data they collect from you, including sensitive personal data, to contact you and personalise their communication. Saga and AXA PPP healthcare also use it for administrative purposes to provide the service you requested and for preparing quotations. If Saga has obtained your permission to do so, they will also contact you by post, telephone, email or other means to tell you about offers, products and services that may be of interest to you. At any time you can opt out of receiving such information, revise the products you would like to hear about or change the method they use to communicate with you. You can update these preferences by calling 0800 056 9271. For further information about how the Saga Group uses your personal information, please visit www.saga.co.uk/privacy-policy.aspx or contact the Saga Group Data Protection Officer by email: data.protection@saga.co.uk or post: The Saga Building, Enbrook Park, Sandgate, Folkestone, Kent CT20 3SE.

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. 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.

In some cases you also have the right to ask us to stop processing your information, and you can ask us to correct any information that is wrong.

If you want to contact Saga or AXA PPP healthcare to exercise any of your rights just call 0800 056 9271 (for Saga) or 0800 027 1331 (for AXA PPP healthcare). Alternatively you can write to Saga at: The Saga Building, Enbrook Park, Sandgate, Folkestone, Kent CT20 3SE or AXA PPP healthcare at: Data Protection Officer, AXA PPP healthcare Ltd, Jubilee House, Vale Road, Tunbridge Wells, Kent TN1 1BJ.

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. Saga and 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 will investigate possible medical malpractice and 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 practise may be impaired.

Keeping information

Saga and AXA PPP healthcare will hold your personal information in accordance with the principles of the General Data Protection Regulation (and associated legislation) and in line with our Data Retention Policies. We are entitled and permitted by law and regulation to retain certain types of data for a reasonable period of time. We will then dispose of your information in a responsible way.

Future underwriter changes

Your Saga Health Insurance **policy** is currently provided and underwritten by AXA PPP healthcare Limited as part of an agreement between Saga Services Limited and them. If you have selected any additional cover options, these may be provided by different insurers. At some time in the future Saga Services Limited 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 health insurance to replace your current **policy**. If this is the case, Saga Services Limited 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**. At this stage you will be given the option to refuse transferral to the new provider. For further information, please see Saga's Privacy Policy at saga.co.uk/privacy-policy.

Legal rights and responsibilities

12.1 Your rights and responsibilities

(a) Your **policy** is an annual insurance contract and lasts 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 14 day cooling-off period the **policy** will continue on the terms described in

this Policy Book for the remainder of the **policy year**.

(h) After the 14 day cooling-off period:
- if you pay monthly premiums the **policyholder** may cancel this **policy**, providing no claims have been made in the **policy year**, by providing 14 days' notice to Saga and we will return any premium paid in relation to any unused period of cover.
- if you pay annual premiums, 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.

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 when 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) We, or any person or company that we nominate, have subrogated rights of recovery of the **policyholder** or any **family members** in the event of a claim. This means that we will assume the rights of **policyholders** or any **family members** to recover any amount to which they are entitled, for example from someone who caused your injury or illness, another insurer or a state healthcare system, and which we have already covered under this **policy**. The **policyholder** must provide any reasonable assistance we may need to enable us to exercise these subrogated rights and must not do anything to prejudice such rights at any time. We reserve the right to deduct from any claims payment otherwise due to you or an amount equivalent to the amount you could recover from a third party or state healthcare system.

(e) If you break any of the terms of the **policy** which we reasonably consider to be fundamental, we may (subject to 12.2(f)) 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.

(f) 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.

(g) We will not do business with any individual or organisation that appears on an economic sanctions list or is subject to similar restrictions from any other law or regulation. This includes sanction lists, laws and regulations of the European Union, **United Kingdom**, United States of America or under a United Nations resolution. We will immediately end cover and stop paying claims on your **policy** if you or a **family member** are directly or indirectly subject to economic sanctions, including sanctions against your country of residence. We will do this even if you have permission from a relevant authority to continue cover or premium payments under a **policy**. In this case, we can cancel your **policy** or remove a **family member** immediately without notice, but will then tell you if we do this. If you know that you or a **family member** are on a sanctions list or subject to similar restrictions you must let us know within seven days of finding this out.

(h) 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.

(i) 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 Policy Book 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.

Active treatment of cancer – **treatment** intended to affect the growth of the **cancer** by shrinking the **cancer**, stabilising it or slowing the spread of disease, and not given solely to relieve symptoms.

Acupuncturist – a medical practitioner who specialises in acupuncture and is registered under the relevant Act, or a practitioner of acupuncture who is a member of the British Acupuncture Council (BAcC), and who, in all cases, meets our criteria for acupuncturist recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise as an acupuncturist 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.

If you have opted for Fixed Fast Track, we must help you choose who provides your **treatment**.

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, 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.

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**.

If you have opted for Fixed Fast Track, the **Saga Countrywide Hospital List** does not apply and we must help you choose where your **treatment** takes place.

Dental practitioner – a registered licensed dental practitioner in general practice.

Diagnostic tests ◊ – investigations, such as x-rays or blood tests, to find 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**.

External prosthesis – an artificial, removable replacement for a part of the body.

Facility – a private **hospital** or a centre with which we have an agreement to provide a specific range of medical services and which is listed in the **Saga Countrywide Hospital List**.

In some circumstances, **treatment** may be carried out at an establishment which provides **treatment** under an arrangement with a facility listed in the **Saga Countrywide Hospital List**.

If you have opted for Fixed Fast Track, the **Saga Countrywide Hospital List** does not apply and we must help you choose where your **treatment** takes place.

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** children. Children cannot stay on your **policy** after the renewal date following their 21st birthday (or 25th birthday if in full-time education).

Fee-approved specialist – a **specialist** who we have identified as someone whose fees for **eligible treatment** we routinely pay in full.

Fee-limited specialist – a **specialist** who we have identified as someone to whom we will only pay up to the amount shown within the Schedule of Procedures and Fees towards their **eligible treatment** charges. If you would like a copy of the Schedule of Procedures and Fees, please contact our Claims Personal Advisory Team.

GP – a general practitioner on the General Medical Council (GMC) GP register.

We will only accept referrals from your NHS **GP** practice or a Saga GP Service **GP**.

Homeopath – a medical practitioner who specialises in homeopathy and is registered under the relevant Act, or a practitioner of homeopathy who holds full membership of the Faculty of Homeopathy, and who, in all cases, meets our criteria for homeopath recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise as a homeopath 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.

If you have opted for Fixed Fast Track, we must help you choose who provides your **treatment**.

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

If you have opted for Fixed Fast Track, the **Saga Countrywide Hospital List** does not apply and we must help you choose where your **treatment** takes place.

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 mental health conditions.

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

Open referral – where your **GP** states that **treatment** is necessary and which type of **specialist** you require that **treatment** from, but does not specify the **specialist's** name.

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**.

Physiotherapist – a medical practitioner who practises physiotherapy and who 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 physiotherapist for benefit purposes. When such persons provide such services to you as part of your **in-patient** or **day-patient treatment**, those services will form part of the private **hospital** charges.

If you have opted for Fixed Fast Track, we must help you choose who provides your **treatment**.

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 Policy Schedule and our letter of acceptance
- any Statements of Fact we have sent you
- any endorsements Saga has sent you.

Policyholder – the first person named on the Policy Schedule who must be 50 or over.

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 practitioner for benefit purposes.

When such persons provide such services to you as part of your **in-patient** or **day-patient treatment** those services will form part of the private **hospital** charges.

The professions concerned are dieticians, **nurses**, orthoptists, psychologists, psychotherapists and speech therapists. A full explanation of the criteria we use to determine these matters is available on request.

If you have opted for Fixed Fast Track, apart from **nurses**, we must help you choose who provides your **treatment**.

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**.

If you have opted for Fixed Fast Track, the **Saga Countrywide Hospital List** does not apply and we must help you choose where your **treatment** takes place.

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**.

If you have opted for Fixed Fast Track, the **Saga Countrywide Hospital List** does not apply and we must help you choose where your **treatment** takes place.

Selected provider – a **hospital**, **day-patient unit**, **scanning centre**, **out-patient facility**, **specialist**, **practitioner**, **therapist**, **physiotherapist**, **acupuncturist** or **homeopath** who we choose to provide your **treatment**.

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.

If you have opted for Fixed Fast Track, we must help you choose who provides your **treatment**.

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.

Therapist – a medical practitioner with full registration under the Medical Acts, who is a practitioner in osteopathy or chiropractic, is registered under the relevant Act and who, in all cases, meets our criteria for therapist recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise as a therapist 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.

If you have opted for Fixed Fast Track, we must help you choose who provides your **treatment**.

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.

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

14 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 Policy Schedule 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 Policy Book.

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 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 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 Policy Schedule 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 abdominal pain) 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 abdominal pain. 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 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 before you incur the costs of treatment.

How do regular check-ups affect the moratorium?

It depends on what check-ups 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 check-ups for that condition, then we will not cover the cost of private treatment received for that condition, or specified 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 check-ups 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 check-ups) if you do not need any medication, treatment, special diets or advice for a continuous period of two years. If you have general health check-ups 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 check-ups in any of the circumstances described above.

Please note:

The preceding questions and answers provide broad guidance to the operation of the moratorium method of underwriting. 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.

Helplines Please have your policy number to hand when calling

This Policy Book is also available in large print, audio and Braille. If you require any of these formats please contact us on **0800 056 9273**.

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

Claims Personal Advisers

For new claims or help with your existing claim

0800 027 1331

If calling from outside the UK

+44 1892 503016 – international call rates apply.

Monday to Friday 8am-8pm,

Saturday 9am-5pm.

Saga GP Service

To speak to a practising GP

0800 027 1333

24 hours a day, seven days a week.

Customer Care Team

To discuss or make changes to your Saga HealthPlan

0800 056 9273

Monday to Friday 8.30am-7pm,

Saturday 9am-1pm, Sunday 10am-2pm.

Saga Health Information Line

To speak to an experienced healthcare professional

0800 17 40 17

24 hours a day, seven days a week.

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