yourchoice

Policy Document

Effective from 1st March 2018

CS healthcare

"CS Healthcare is definitely the best healthcare provider I have experienced – the service is excellent and when you telephone the staff are always polite, friendly & helpful."

Mrs C Thierry

Contents

Introduction

This Policy Document sets out the details of **your choice** health insurance; including all policy rules and guidance notes. Please refer to your Registration Certificate for confirmation of the options you have chosen, for the details of the persons covered under the policy, any restrictions that may apply and any voluntary excess or co-payment option selected. Under **your choice** health insurance there is a compulsory level of cover: Essential alongside four additional options:

- Expert Diagnostics (for further details please refer to the schedule of benefits (D2)),
- Therapy & Care (for further details please refer to the schedule of benefits (D3)),
- Heart & Cancer (for further details please refer to the schedule of benefits (D4)),
- and Cash Benefits (for further details please refer to the schedule of benefits (D5)),

It is important that you read this Policy Document carefully and in conjunction with Schedule B: Directory of Hospitals, Schedule C: Registration Certificate and Contribution rates and Schedule D: Benefit Schedules (found within this Policy Document). The **your choice** policy is designed to provide cover for the treatment of Acute Medical Conditions. By this we mean those conditions, diseases or illnesses that respond to short term treatment with the aim of returning you to the state of health you were in before suffering the disease, illness or injury. These policies do not cover treatment of a Chronic Medical Condition or long-term condition.

If you would like this Policy Document or any of our literature in a large print, audio or Braille format please contact our Membership Services Team.

Advice Lines

For general enquiries call our Membership Services Team on 020 8410 0400^
Lines are open Monday to Friday (excluding public holidays) from 9am to 5pm.

For requesting a Claim Form and pre-authorising treatment call our Claims Helpline on 020 8410 0440^
Lines are open Monday to Friday (excluding public holidays) from 8am to 6pm. For contacting our Managed Care Team, for example authorising treatment for cancer, please contact 0208 547 4998^

For 24 hour advice on health issues call our Lifeline on 020 8410 0415
We offer a health advice and assessment service, with Doctor call back, called Lifeline. This service is staffed by experienced nurses who are trained to provide advice and assistance across a range of medical issues. Lifeline is available 24 hours a day, 365 days a year with no limit on the number of times you can call the service. All calls are strictly confidential and follow the Nursing and Midwifery Council's 'The Code' - Professional standards of practice and behaviour for nurses and midwives.

By calling Lifeline you get access to:

- A Nurse Adviser on call 24 hours a day for medical advice and assessment.
- Medical advice from a Doctor via a telephone appointment service at a time convenient to you.
- Direction and advice on other medical services.

Member Responsibilities

As a member of CS Healthcare we request that you accept the following responsibilities:

Application for membership If you give false or misleading information (whether innocently or fraudulently) on application for health insurance cover; and this information would have affected the decision to insure you, the cover will end, and the Society will not pay any benefit to you.

Keeping the Society informed You must keep the Society informed about any changes to the original information that you provided to us. This includes but is not restricted to: change of address, change of name or circumstances.

Premium payments You must make sure that premium payments for the policy are paid on time and at the agreed amount for all those insured under your policy. A premium is deemed due on your policy effective date and for monthly payers on the same day of the month thereafter. If a premium is not paid within 60 consecutive days of this date, the Society will automatically cancel the policy and all claim entitlements will cease. The Society also reserves the right to cancel the policy if the premiums are not paid on time for a total of 3 payments during any 12 month period.

You should be aware that if there are premium arrears on a policy, benefit will not be payable for any treatment received during the arrears period until the arrears have been settled in full. Policy changes or amendments are not permitted while a policy is in arrears.

If the Society cancels your policy because it has fallen

into arrears by more than 60 days or premiums have not been paid on time for a total of 3 payments in any 12 month period, you may not be eligible to re-join under the original policy terms. However, you can apply to re-join the Society, and any such application will be re-underwritten. The Society reserves the right to decline future applications for membership.

Claims You must seek pre-authorisation and confirmation of cover before proceeding with treatment. For information about our claims procedure and guidelines please refer to the 'How to Claim for Health Insurance' section and 'How to Claim under the Cash Benefits option' within this Policy Document. Failure to pre-authorise a claim may lead to non-payment.

Please be aware, if you make a claim for symptoms that initially occur within the first year of membership, we will ask you to provide a copy of the GP referral letter for assessment of your claim.

^ Calls to CS Healthcare will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

EMERGENCY TREATMENT IS NOT COVERED; IN AN EMERGENCY YOU SHOULD CALL AN NHS AMBULANCE AND/OR VISIT AN NHS ACCIDENT & EMERGENCY DEPARTMENT.

Emergency Treatment is defined as an admission to:

- a hospital directly following an accident, or
- a hospital ward directly from the emergency department for urgent or unplanned treatment, or
- a hospital ward on the same day as a referral for treatment is made either by a GP or specialist, when immediate treatment or diagnostic tests are necessary, or
- a hospital to receive immediate lifesaving surgery.

General Terms and Conditions

This policy is only available to you if you are a permanent resident in the United Kingdom and registered with an NHS GP who is not a direct family member.

When dealing with the Society you act on behalf of every dependant included on your policy.

Email and post will be used for all correspondence in respect of you and your dependants covered under the policy unless otherwise agreed by the Society.
You must therefore advise us immediately of any change of address.
The Society is guided by its not-for-profit status – as a friendly society we aim to provide a professional and personal service to our members. The Society may amend policy terms and conditions, including, but without limiting the foregoing, changing the benefits provided, for the following reasons:

- to enable the Society to meet its general legal and regulatory responsibilities;
- to allow the Society to respond to changes in the general law or regulation or to decisions of the Financial Ombudsman Service;
- to reflect legitimate cost increases or reductions associated with providing cover.

The Society will give members one month's notice of any such change by writing to them at their last known address according to the Society's records.

The Society reserves the right to:

- cancel this policy on non-payment of any premium or any other sum payable by the member under the terms of this policy;
- cancel this policy or terminate or change a member's cover if the member has:
  - misled the Society by misstatement or concealment, knowingly or otherwise;
  - assisted or concealed any attempt by any third party to defraud the Society;
  - otherwise failed to observe the terms and conditions of this Policy or the Memorandum of Association and Rules.

The membership agreement is governed by and is subject to the law of England and Wales.

Invalid benefit payments
If you break any of the terms of membership or make, or attempt to make, any dishonest or reckless application or claim the Society shall be entitled to:

- refuse to pay any benefit
- cancel the membership immediately.

If the Society makes any payments to you as a result of fraud, recklessness or negligence the following actions may take place:

- your membership will be cancelled immediately
- the Society may demand that any benefits paid to you are reimbursed to the Society
- the Society may take legal action against you for the return of such monies paid out to you in benefit. It may be demanded that you reimburse the Society for any investigation costs incurred.

your choice health insurance - summary

your choice offers a flexible choice of cover so you can create your own package of health protection. Choose from four cover options to

meet your needs for treatment and care received in the United Kingdom.

Essential: this compulsory part of your health insurance gives you comprehensive cover for treatment and care for eligible conditions (please refer to the 'Essential-schedule of benefits' section within this Policy Document for details) and undiagnosed symptoms. Essential gives you access to in-patient and day-patient care for surgery and medical admissions, out-patient surgical procedures, including all related hospital costs and Consultant's fees and specialised scans like CT & MRI scans. In addition to these benefits there is a 90 day period of necessary aftercare available which provides cover for post-operative consultations, investigations, tests and physiotherapy. If required, there is also cover for nursing at home or convalescence and private road ambulance fees. NHS cash allowance is available should you opt to have treatment in an acute NHS general hospital. See the 'Essential-schedule of benefits' within this Policy Document for full details.

Additional cover options:

Expert Diagnostics: this option gives you quick access to out-patient investigations and consultations for an acute illness or injury. You will have cover for consultations with a registered Consultant, investigations including blood tests, ultrasound scans and x-rays, therapeutic injections, dressings and wound care. Dietary advice under the supervision of your Consultant for treatment of a medical condition and up to £1000 benefit for out-patient psychiatric consultation and counselling is also covered under the full cover option.

Choose from 3 levels of cover for Expert Diagnostics (for further details please refer to the schedule of benefits (D2)):

- Expert Diagnostics Comprehensive
- Expert Diagnostics 1000: a £1,000 limit for diagnostic treatment per person per policy year (excludes psychiatric cover),
- Or Expert Diagnostics 500: a £500 limit for diagnostic treatment per person per policy year (excludes psychiatric cover),.

See the 'Expert Diagnostics-schedule of benefits' section within this Policy Document for full details. Please note, you can only select one Expert Diagnostics level on your policy. If you choose a limited benefit option, (this will be confirmed on your Registration Certificate) you have a set amount of benefit to claim, therefore if your treatment exceeds the amount of funds you have available you may continue to fund your treatment yourself or you will have to change your care to the NHS.

Therapy & Care: this option gives you fast access to a therapist, or other recognised practitioners for out-patient therapy and care following hospital admissions either newly diagnosed or following your 90 day necessary aftercare period available under Essential. You also have cover for physiotherapy, osteopathy, chiropractics, and the complementary therapies of homeopathy and acupuncture. A home help and appliances benefit is also available following your discharge from hospital. See the 'Therapy & Care-schedule of benefits' section within this Policy Document for full details.

Heart & Cancer: this option gives you access to in-patient and day-patient care for heart and/or cancer surgical and medical admissions, out-patient surgical procedures, including all related hospital costs, Consultant's fees, specialised scans such as, CT & MRI and investigations and physiotherapy for heart and cancer. For cancer conditions a period of necessary aftercare is available (including diagnostics, specialised scans, investigations and physiotherapy) for up to 5 years from the date of diagnosis. For heart conditions a period of necessary aftercare is also available including diagnostics, specialised scans and investigations and supportive care for 1 year from the date of admission for each acute heart condition.

Alternatively, members may be entitled to benefit available under the Your Care Package and NHS cash allowance (if treatment is taken as an NHS patient).

Choose from 2 levels of cover for Heart & Cancer (for further details please refer to the schedule of benefits (D4)):

- Heart & Cancer Comprehensive
- or Heart & Cancer Limited: a £50,000 limit for each Heart condition and an additional £50,000 for each Cancer condition.

See the 'Heart & Cancer-schedule of benefits' within this Policy Document for full details. Please note, you can only select one Heart & Cancer level on your policy. If you choose the limited benefit option, (this will be confirmed on your Registration Certificate) you have a set amount of benefit to claim, therefore if your treatment exceeds the amount of funds you have available you will have to change your care to the NHS or you may continue to fund your treatment yourself.

Cash Benefits: this option gives you cash reimbursement up to agreed limits, for visits to the

dentist, hygienist, for prescription contact lenses, and towards a full Health Screening. See the 'Cash Benefit-schedule of benefits' within this Policy Document for full details.

Hospital lists:

In addition to the above options, you have a choice of two hospital lists: Partnership and Extended.

Voluntary excess or co-payment:

You also have the option to reduce your premium payments by taking a voluntary excess or co-payment. Any reduction in policy premium in lieu of an excess or co-payment option is not applied to the Therapy & Care and Cash Benefits options.

Essential – schedule of benefits (D1)

BENEFIT	COVER	NOTES
Hospital care for in-patient, day-patient treatment and out-patient surgery for pre-authorised treatment that takes place in any hospital from your chosen hospital list		
Specialised scans	Covered*	You are covered for Nuclear Scans, CT, MRI, PET, DAT, MIBG, Myelogram, Thallium and Perfusion/Ventilation scans.
Out-patient surgery and related charges	Covered*	Pre-authorised out-patient surgical procedures performed in an out-patient theatre, which are not performed as part of a Consultation in a consulting or treatment room.
Pre-operative tests to assess your fitness for surgery	Covered*	For up to 2 weeks prior to an authorised hospital admission to cover blood and urine tests, chest X-ray, ECG and assessment with an Anaesthetist if required.
Post-operative consultations, investigations, tests and physiotherapy	Covered*	As a part of necessary aftercare within 90 days immediately following a planned pre-authorised private hospital admission.
Surgical admissions related hospital charges including implanted surgical prosthesis	Covered*	Where you require surgery (including endoscopic procedures) cover will apply according to the average length of stay (for your surgical procedure) either as a day-patient or in-patient, including implanted prosthetics and all hospital surgical consumables.
Medical admissions and related services	Covered*	Where a stay as either a day-patient or in-patient is required for either diagnostic reasons or to treat and stabilise an acute condition by medical and by non-surgical means.
Specialist/Consultant fees	As per the CS Healthcare Fee Schedule	All Specialist/Consultant fees will be paid for medical, consultant, physician supervisions according to the rates of the CS Healthcare Fee Schedule. Please refer to the medical fees section of our website www.cshealthcare.co.uk or call our Claims Helpline on 020 8410 0440^ for full details.

BENEFIT	COVER	NOTES
Surgeon and Anaesthetist fees	As per the CS Healthcare Fee Schedule	All Surgeon and Anaesthetist fees will be paid according to the rates of the CS Healthcare Fee Schedule. Please refer to 'Surgeon and Anaesthetist Fees' section within the Policy Document and the medical fees section of our website www.cshealthcare.co.uk or call our Claims Helpline on 020 8410 0440^ for full details.
Private road ambulance	Up to £250 per person per policy year	Where required out of medical necessity after hospitalisation.
Convalescing and Nursing at Home	Up to a maximum of 14 days and £2,800 each admission	Immediately following a hospital admission either as an NHS or private patient under the specific direction of a Specialist/Consultant.
Parent accommodation	Covered*	For one or both insured parents staying with an insured child up to age of 16.
NHS cash allowance	£150 each night or day case admission to a UK NHS acute general hospital	Up to 28 nights inclusive of day case admissions (up to a maximum of £4,200) per person per policy year for eligible claims under this option.
Additional features		
Your Care Package	Discretionary	A tailor-made discretionary package of care, agreed in advance of treatment, for those members electing to receive all or part of their treatment on the NHS.Your Care Package is considered for in-patient treatment only and does not cover out-patient treatment.
Out of band hospital benefit	Covered*	When using a hospital not included in our Directory of Hospitals, or included in your level of cover, we will consider reimbursement directly to you based on a customary and reasonable fee from a hospital on your list
Lifeline	24 hour availability 365 days a year	Health advice line with Doctor call back service.
Voluntary excess options	£100, £300, £500 £1000, £2000	Voluntary excess chosen will only apply to Essential cover, Expert Diagnostics and Heart & Cancer. Please refer to the 'Voluntary Excess and Co-payment options' section within the Policy Document for further details.
Co-payment option	15% of claims up to either £1000 or £3000 per person per policy year	The co-payment option will only apply to Essential cover, Expert Diagnostics and Heart & Cancer. Please refer to the 'Voluntary Excess and co-payment options' section within the Policy Document for further details.
*All costs must be necessary, customary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received, provided you use a hospital on your list.		

IMPORTANT NOTES:

1. Please note, **we will not pay** overnight hospital accommodation and related charges which are related to treatment that would normally be carried out as a day-patient or out-patient; for the purpose of convalescence or rehabilitation; for therapies including complementary; for early admission or late discharge or for the purpose of personal need and/or social arrangements not associated with an acute medical need or the expected length of stay which is displayed on your Pre-authorisation Certificate of cover.

2. Heart and cancer conditions are not covered by Essential. If you are having symptoms investigated which are diagnosed as a heart or cancer condition, cover will cease under this option once the necessary aftercare period has passed. Heart conditions that arise as a complication alongside another eligible condition will be covered. Please see the 'Heart & Cancer-schedule of benefits' within this Policy Document for clarification of what is exactly covered.

3. You are not covered for Emergency Treatment (See 'Emergency Treatment' definition on page 42).

4. You will be covered after you have been discharged from hospital for a **90 day period of necessary aftercare.** This will include cover up to a maximum of 3 post-operative or follow-up consultations, 6 sessions of physiotherapy, where related directly to your surgery or medical admission to check your progress or treat any complications. Wound care, application or re-application of plaster of paris, casts, splints, braces, other dressings and small procedures will also be covered when they are a direct consequence of your surgery or medical admission.

5. Where diagnostic endoscopies, biopsies or similar procedures are performed we will cover one follow-up consultation to collect the results. Ongoing consultations for diagnostic purposes or to plan a further procedure are not covered. Where genuine post-operative complications have occurred, or stabilisation of a medical condition is still being sought within the 90 day necessary aftercare period, we will give further consideration to cover on submission of a treatment plan from the Specialist/Consultant.

6. Cover for specialised scans covers the cost of the actual scan and radiological reporting. Pre and post scan consultations are not covered unless you have chosen the Expert Diagnostics cover option.

7. NHS cash allowance is payable for admissions into care in an acute general hospital for treatment of acute conditions, only where no transfer or admission from or to private care takes place for the same or related medical or surgical episode and any related complications; this excludes transfers into rehabilitation facilities, long–stay or psychiatric hospitals.

Cover is for an acute condition curable within the short term; refer to page 20 of your policy document for further details.

Expert Diagnostics option – schedule of benefits (D2)

BENEFIT	COVER			NOTES
	Out-patient benefits			
	Expert Diagnostics Comprehensive	Expert Diagnostics 1000	Expert Diagnostics 500	
Consultations with a Specialist/Consultant	COVERED*	COVER LIMITED TO £1,000*	COVER LIMITED TO £500*	On referral from your GP, Optician or Dentist or another Specialist/Consultant in a consulting or treatment room. You are also covered if you wish to seek a second opinion or a referral to another Specialist/ Consultant if necessary.
Investigations and tests: Including blood tests, ECG, EEG, ultrasound scan, X-rays and related tests				As part of consultant supervised care or on GP referral.
Treatment room procedures such as excision of lesions, small biopsies and cryotherapy and any related pathology. Therapeutic injections for pain relief or to treat specific symptoms Dressings and wound care Application or re-application of plaster of paris, casts, splints and braces				As part of consultant supervised treatment.
Dietitian Audiology Optometry				Under the supervision of your Specialist/Consultant for treatment of an eligible medical condition.
Psychiatric consultations and counselling	Up to £1000 per person per policy year and available only under Expert Diagnostics Comprehensive	No cover	No cover	On referral from your GP or another Specialist/ Consultant to a Consultant Psychiatrist or recognised Counsellor

*All costs must be necessary, customary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received, provided you use a hospital on your list.

IMPORTANT NOTES:

Heart and Cancer conditions are not covered by the Expert Diagnostics option, if you have symptoms investigated which are then diagnosed as a heart or cancer condition, no further cover will be given under Expert Diagnostics.

For full details of what we **will not pay**: please refer to the 'General Policy Exclusions' and 'Specific Treatment Exclusions and Advice' sections in this Policy Document.

Therapy & Care option – schedule of benefits (D3)

BENEFIT	COVER	NOTES
Manipulative out-patient benefits		
Physiotherapy Osteopathy Chiropractic treatment Sports therapy	Covered*	On either referral from your General Practitioner or under supervision from a Specialist/Consultant. We will initially pre-authorise 2 sessions in the first instance, if more treatment is required we will expect the Therapist to supply a Treatment Plan on request so we can confirm what further cover is available.
Complementary out-patient benefits		
Acupuncture Homeopathy	Covered*	On either referral from your General Practitioner or under supervision from a Specialist/Consultant. We will pre-authorise 2 sessions in the first instance, if more treatment is required we will expect the Therapist to supply a Treatment Plan on request so we can confirm what further cover is available. Excludes the costs of medicines or remedies.
Treatment and recovery benefits		
Chiropody and Podiatry	Up to £400 per person per policy year	To treat in-growing toenails, verrucas and for biomechanical assessment and orthotics.
Speech therapy	Covered*	Following a cerebrovascular accident, surgery or trauma to the vocal cords.
Occupational therapy	Covered*	Following an acute illness, or following an NHS in-patient admission to assess your needs or your activities of daily living or for a pre agreed course of therapy to aid recovery.
Appliances/aids following in-patient admission	Up to £400 per person per policy year	For example, raised toilet seats, grab rails, walking sticks, zimmer type frames, bath stools and bath aids, chair raises or special chairs. Available when recommended by a Consultant or Therapist.
Home help	Up to £700 each admission	Immediately following a hospital admission, under the specific direction of the Specialist/Consultant and carried out by a registered home help or carer.
***All costs must be necessary, customary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received provided that the practitioner used is registered with the appropriate regulatory body as detailed on page 7/8 of the your choice Directory of Hospitals.**		

Please note: no excess or co-payment is applicable to this option.

For full details of what we **will not pay**: please refer to the 'General Policy Exclusions' and 'Specific Treatment Exclusions and Advice' sections in this Policy Document.

Heart & Cancer option – schedule of benefits (D4)

HEART BENEFIT	COVER		NOTES
In-patient, day-patient and out-patient treatment			
	Heart & Cancer Comprehensive	Heart & Cancer Limited	
Surgical admission: for Heart (cardiac) surgery including implanted prosthesis, including valves and related hospital charges	**COVERED***	**COVER LIMITED TO £50,000* (per condition for the lifetime of the policy)**	This covers both open & closed surgical procedures. Covered for accommodation, theatre costs and all related investigations and medical costs like physiotherapy and dietitian. All Surgeon and Anaesthetist fees will be paid according to the rates of the CS Healthcare Fee Schedule. Please refer to the medical fees section of our website www.cshealthcare.co.uk or call our Claims Helpline on 020 8410 0440^ for full details.
Non-surgical admission: Heart (cardiac) medical care including related hospital charges			Covered for accommodation, theatre and all related investigations & medical cost and Consultant fees. Where a stay is either for a day-patient or overnight patient is required for either diagnostic reasons or to treat and stabilise an acute condition by medical and by non-surgical means.
Heart (cardiac) necessary aftercare; including diagnostics, specialist physiotherapy/ rehabilitation and supportive care including care of a Registered Dietitian within 1 year from the date of admission for each acute condition treated or Acute episodes of a previously covered condition, to investigate and stabilise the symptoms in the short term.			Following a privately funded hospital admission or an acute recurrence of a condition pre-authorised by CS Healthcare, you are also covered for consultations & investigations including; CT, MRI, scans & investigations, PET, DAT, MIBG, Myelogram, Thallium and Perfusion/Ventilation scans. Covered for procedures such as angiograms, transoesophageal echocardiograms, electrophysiological studies, cardioversion and pacemaker insertion and checks. If a new and separate heart condition requires admission as described above and this occurs during an already pre-authorised 12 month follow-up period, the period of necessary aftercare will be extended from the date of the new admission date accordingly.

CANCER BENEFIT	COVER		NOTES
In-patient, day-patient and out-patient treatment			
	Heart & Cancer Comprehensive	Heart & Cancer Limited	
Place of treatment: You are *covered* for: treatment in a hospital from your chosen hospital list or a Home care provider from your chosen hospital list	**COVERED***	**COVER LIMITED TO £50,000*** (per condition for the lifetime of the policy)	• Hospital - in-patient & day-patient • Hospital - out-patient • At home For all Accommodation, theatre, related hospital costs and Consultant fees related to a surgical or medical admission to treat your condition and any related complications.
Hospice Donation			Hospice Donation of £400 per person per policy year.
Diagnostic (after confirmed diagnosis of Cancer You are *covered* for: Consultant Visits from a provider chosen from your hospital choice for all relevant blood tests, X-rays & Scans, Biopsy and aftercare			• Consultant lead Care and Cancer Nurse Specialist Care. • Diagnostic test, to aid diagnosis, monitor your treatment and to follow you up to 5 years after diagnosis and according to your medical need. • Including Ultrasound, CT, MRI & PET, MIBG Thallium, Perfusion & Ventilation scans. • Genetic & predictive disease profiling associated with eligible conditions.
Surgery You are *covered* for: Surgery from a provider chosen from your hospital choice and for Specialist/Consultant Fees involved in your care, including all related hospital, therapy and specialist nursing costs.			• Removal of Primary & Secondary cancers • Surgical Intervention for relief of symptoms and disease management, including palliative procedures. • The initial reconstructive surgery within 5 years of the first procedure or on completion of Radiotherapy and Chemotherapy treatment.
Preventative: You are *covered* for: Home care from a provider chosen from your hospital choice and for the delivery of symptom prevention, and associated investigations and consultant supervision or Where home care is not available from a hospital chosen from your hospital choice			• Investigation as part of your disease management is covered. • Bone Strengthening drugs and therapies to manage disease progression are covered. Vaccines - are not covered and are available from your NHS GP.

CANCER BENEFIT	COVER		NOTES
In-patient, day-patient and out-patient treatment			
	Heart & Cancer Comprehensive	Heart & Cancer Limited	
Drug therapy: You are *covered* for: Home care or hospital care from a provider chosen from your hospital list and for the delivery of drug therapy to treat and control or maintain your disease and related symptoms	**COVERED***	**COVER LIMITED TO £50,000*** **(per condition for the lifetime of the policy)**	• Intravenous Chemotherapy & Biological therapies • Oral Chemotherapy & Biological therapies from a recognised provider • Supportive drug therapy such as Steroids, anti sickness, antibiotics, pain relieving medications as an in-patient and 7 days take home drugs following an admission • Drugs licensed to treat specific cancers, which have been assessed by NICE as safe and effective. • All accommodation, insertion of lines and related hospital costs and Consultant and Specialist nursing fees.
Radiotherapy You are *covered* for: Hospital care from a provider chosen from your hospital list and for the delivery of radiotherapy to treat and control or maintain your disease and related symptoms			• We cover external radiotherapy and internal radiotherapy, and brachytherapy. • Treatment of primary and secondary cancers. • Treatment for pain relief and to maintain remission. • To treat recognised complications
Palliative: You are *covered* for: Care to treat, relieve and control symptoms, including pain relieving treatment, either independently or alongside surgery, or radiotherapy			• Maintenance therapy including radiotherapy and drug therapy as described above. • Complementary Therapies to relieve symptoms.
End of life care You are *covered* for: Hospice Donation: Care and treatment in a hospital from your chosen hospital list or a Home care provider from your chosen hospital list, as a private patient when hospice care is unavailable			• Hospice Donation £400 per person per policy year • For all accommodation, theatre, related hospital costs and Consultant fees related to a medical admission or home treatment to support your end of life care and any related complications.

CANCER BENEFIT	COVER		NOTES
In-patient, day-patient and out-patient treatment			
	Heart & Cancer Comprehensive	Heart & Cancer Limited	
Nursing at home, as a private patient when hospice care is unavailable.	**COVERED***	**COVER LIMITED TO £50,000* (per condition for the lifetime of the policy)**	• For care at home provided by a registered care provider.
Monitoring: You are *covered* for: Supervision and monitoring of your treatment while receiving active care such as drug therapy or radiotherapy during primary or secondary care of your condition Necessary aftercare per Cancer condition including consultations, for up to 5 years following the initial diagnosis of your condition			• You are covered for consultations and tests during a period of active care and for up to 5 years from the diagnosis of your condition and according to medical need including care of secondary conditions. • Including cover for Ultrasound, CT, MRI & PET, MIBG, Thallium, Perfusion & Ventilation scans. • If secondary disease occurs outside the 5 year monitoring period a maximum of 3 consultations will be covered following completion of drug therapy and radiotherapy or further surgical intervention. • Counselling, under the direction of your consultant. • Dietitian, under the direction of your consultant.
Other benefits **If Heart & Cancer Limited is selected these benefits will be deducted from the £50,000 overall benefit limit**			
Convalescing and Nursing at Home	Up to a maximum of 14 days and £2,800 each admission immediately following a hospital admission either as an NHS or private patient under the specific direction of a Specialist/Consultant.		
Private Road Ambulance	£250 per person per policy year where required out of medical necessity after hospitalisation.		
NHS Cash Allowance	For a surgical or medical admission; £150 each day/night after admission to a UK acute general NHS hospital for up to 28 days per person per policy year for eligible claims. OR For chemotherapy treatment; £60 per day case or overnight admission for the administration of intravenous chemotherapy at an UK acute general NHS hospital. OR For radiotherapy treatment; £30 per fraction of radiotherapy administered at an UK acute general NHS hospital		
Your Care Package	A tailor-made, discretionary package of care agreed in advance of treatment, for those members electing to receive all, or part, of their treatment on the NHS. Your Care Package is considered for in-patient treatment only and does not cover out-patient treatment.		
*** All costs must be necessary, customary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received, provided you use a hospital on your list.**			

IMPORTANT NOTES:

1. Please note, **we will not pay** overnight hospital accommodation and related charges which are related to treatment that would normally be carried out as a day-patient or out-patient; for the purpose of convalescence or rehabilitation; for therapies including complementary; for early admission or late discharge or for the purpose of personal need and/or social arrangements not associated with an acute medical need or the expected length of stay which is displayed on your Pre-authorisation Certificate of cover.

2. You are not covered for Emergency Treatment (See 'Emergency Treatment' definition on page 42).

3. For full details of what we **will not pay:** please refer to 'General Policy Exclusions' and 'Specific Treatment Exclusions and Advice' sections in this Policy Document.

4. You will be covered for heart and cancer treatment, following a confirmed diagnosis of one of these conditions. When considering 'Heart & Cancer' cover please refer to Specific Treatment Exclusion 'S1' in this Policy Document for details as to what is covered within Unlicensed / Experimental treatment.

5. By confirmed diagnosis we mean: that you have had symptoms investigated and as a result it has been confirmed that you have a heart (cardiac) or cancer (oncology) condition. Some elements of your diagnostics may have been covered by Essential or the Expert Diagnostics option (if chosen) otherwise the diagnostic care will have been either funded by yourself or as an NHS patient.

6. By heart we mean: any illness, disease or congenital defect of the heart, including the myocardium (heart muscle), pericardium and the endocardium, heart valves, conducting system, blood vessels and great blood vessels including the aorta, pulmonary artery and veins, and the vena cava. For example:

- Coronary Artery Disease
- Ischaemic Heart Disease

} Angina, Myocardial Infarction (heart attack)

- Major Vessel Disease – Aortic conditions affecting your veins or arteries (with the exception of varicose veins, vascular surgery for limbs and lymphatic system, these are covered under Essential)
- Valve Disease requiring replacement – of the Aortic, Bicuspid (mitral), Tricuspid, Pulmonary valves
- Aortic Aneurysm
- Conduction/Rhythm Disorders - like Atrial Fibrillation, Syncope, Bradycardia
- Cardiac Failure
- Cardiomyopathy
- Pericarditis/Endocarditis

7. By cancer we mean: any type of brain tumour and malignant neoplastic disease. For example

- Breast Cancer
- Colon Cancer
- Oral Cancers
- Skin Cancers – Basal Cell Carcinoma – Malignant Melanoma
- Prostate Cancers
- Lymphomas - Hodgkin's and Non-Hodgkin's Lymphomas
- Blood Cancers Myeloma and Leukaemia
- Bone Cancers

8. NHS cash allowance is payable for admissions into care in an acute general hospital for treatment of acute conditions, only where no transfer or admission from or to private care takes place for the same or related medical or surgical episode and any related complications; this excludes transfers into rehabilitation facilities, long–stay or psychiatric hospitals.

9. Wound care, application or re-application of plaster of paris, casts, splints, braces and other dressings will also be covered within 90 days of discharge from hospital when they are a direct consequence of a pre-authorised surgical or medical admission.

Cash Benefits option – schedule of benefits (D5)

CASH BENEFITS	COVER	NOTES
	Out-patient benefits	
Benefit amounts are per person per policy year per type of cover **Level 1:** Up to £50 **Level 2:** Up to £100 **Level 3:** Up to £150 **Level 4:** Up to £200	**Dental treatment** Check-ups, orthodontic, peri-odontal and hygienist treatment	Benefit is not payable in respect of treatment under dental capitation schemes and dental insurance. This benefit does not exclude any dental related condition that was in existence prior to the start of the policy i.e. pre-existing condition.
	Optical treatment Eye examinations, prescription glasses or sunglasses and prescription contact lenses	No benefit is payable towards the cost of the following – ▪ Repairs to glasses. ▪ Eye laser surgery. ▪ Frames without lenses. ▪ Contact lenses used for cosmetic purposes. ▪ Contact lens solution. ▪ Non-prescription glasses or sunglasses. This benefit does not exclude any eye related condition that was in existence prior to the start of the policy i.e. pre-existing condition.
	Health Screening Health Screening to assess the state of your general health to include: Wellwoman & Wellman Screening, Breast Cancer Screening, Osteoporosis Screening, Bowel Cancer Screening, Cervical Screening, Executive check-ups	▪ Any claim for Health Screening must have been carried out by a recognised Health Screening Centre under the supervision of a registered Physician. ▪ CS Healthcare will not pay any benefit towards Health Screenings other than the ones listed opposite. ▪ CS Healthcare will not pay benefit for a Health Screening undertaken for the purpose of the member's employment, legal or insurance reasons. ▪ CS Healthcare will not pay Health Screening benefit for any child dependant under the age of 25 years. ▪ CS Healthcare will not pay benefit for missed appointment fees.

IMPORTANT NOTES:

In order to claim benefit for Dental and Optical treatment there is a qualifying period of 3 months continual Cash Benefits membership. During this qualifying period, no benefit is payable.

In order to claim Health Screening benefit there is a qualifying period of 12 months continual Cash Benefits membership. During this qualifying period, no benefit is payable.

The Your Care Package

The Society, at its discretion and in advance of treatment, may offer alternative benefits under Essential and Heart & Cancer termed the Your Care Package, for those members opting to have NHS care in lieu of private treatment.

Your Care Package is considered for in-patient treatment only and does not cover out-patient treatment.

Your policy covers you for private treatment (subject to the terms and conditions of your policy). However, if you choose to have your treatment free of charge on the NHS, CS Healthcare can put your benefit to an alternate use to assist your individual needs. This could include child care, aids to assist you around the house, pet care and travel allowance.

Once your condition has been diagnosed by your Specialist/Consultant and you have discussed the treatment options available to you, please contact our Managed Care Team on 020 8547 4998^.

If you opt for NHS treatment, we will draw up an agreement with you confirming the care which will be covered by CS Healthcare.

As a guide, the benefit available will be limited to 10% of the customary and reasonable benefit available for the same treatment privately.

You can request a factsheet explaining the Your Care Package by calling the Claims Helpline on 020 8410 0440^.

Please note that not all cases are suitable for the Your Care Package and we would only pay benefits in lieu of any benefits that you may be entitled to under your chosen level of cover.

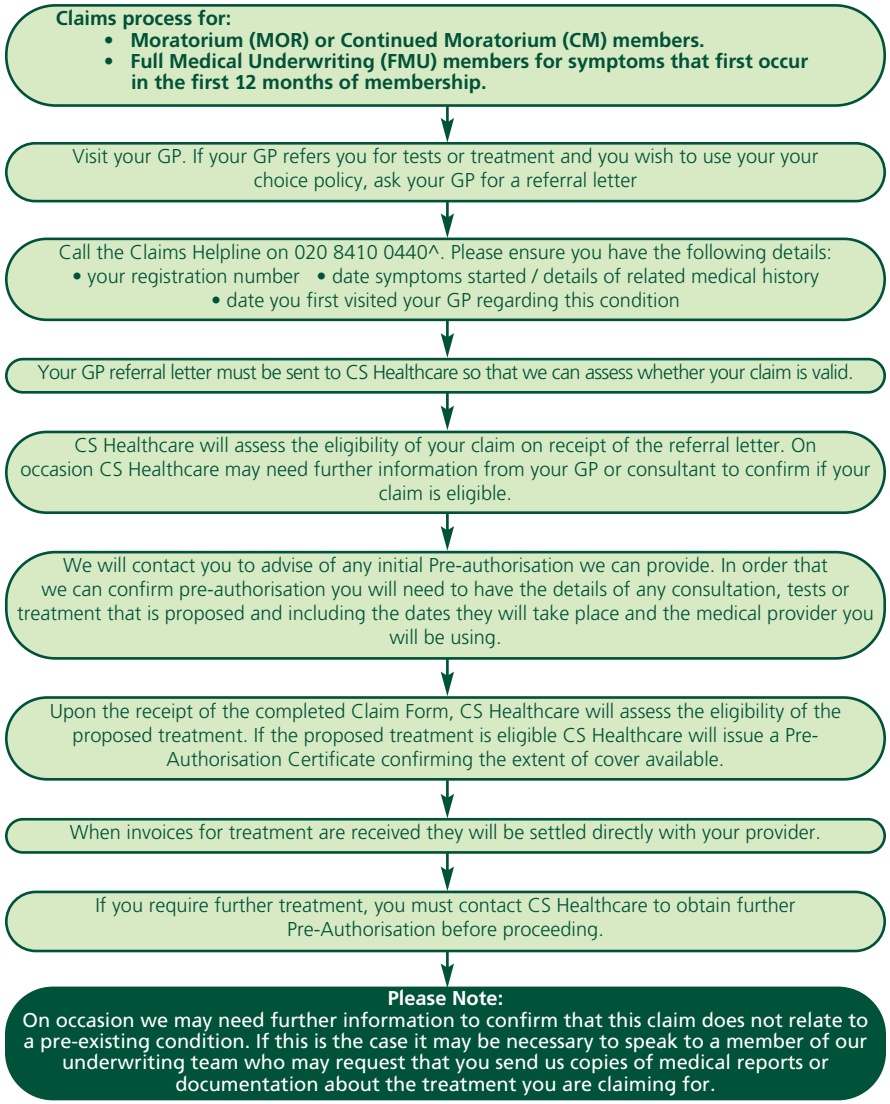
The final decision whether to offer the Your Care Package will be made by CS Healthcare.

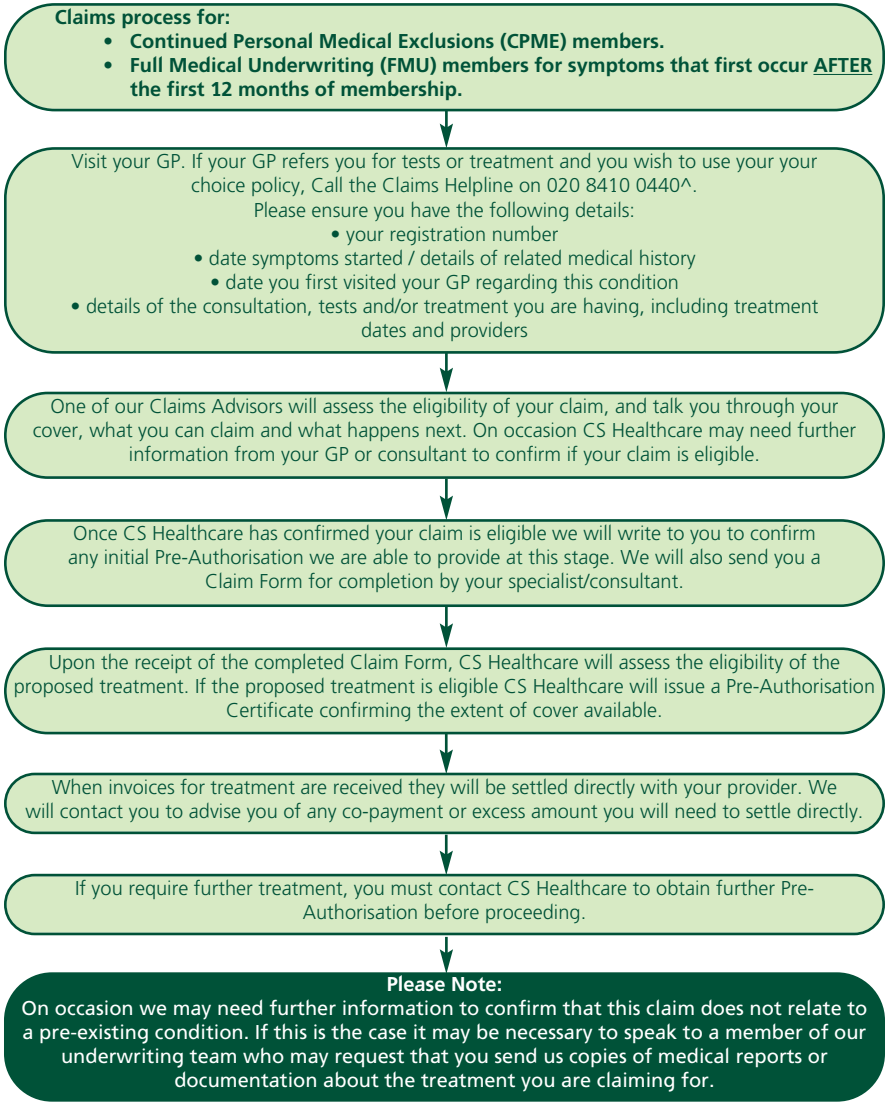
^ Calls to CS Healthcare will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

How to Claim for Health Insurance

If your claim is pregnancy related please ask to speak to the Managed Care Team on 020 8547 4998^. Please see below for the claims process for your chosen method of Underwriting. If you are unsure as to which process applies to you or which underwriting method you have selected please refer to your Registration Certificate or alternatively please contact the Membership Services Team on 020 8410 0400^.

^ Calls to CS Healthcare will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.




Claims process for:
• Continued Personal Medical Exclusions (CPME) members.
• Full Medical Underwriting (FMU) members for symptoms that first occur AFTER the first 12 months of membership.
Visit your GP. If your GP refers you for tests or treatment and you wish to use your your choice policy, Call the Claims Helpline on 020 8410 0440^.
Please ensure you have the following details:
• your registration number
• date symptoms started / details of related medical history
• date you first visited your GP regarding this condition
• details of the consultation, tests and/or treatment you are having, including treatment dates and providers
One of our Claims Advisors will assess the eligibility of your claim, and talk you through your cover, what you can claim and what happens next. On occasion CS Healthcare may need further information from your GP or consultant to confirm if your claim is eligible.
Once CS Healthcare has confirmed your claim is eligible we will write to you to confirm any initial Pre-Authorisation we are able to provide at this stage. We will also send you a Claim Form for completion by your specialist/consultant.
Upon the receipt of the completed Claim Form, CS Healthcare will assess the eligibility of the proposed treatment. If the proposed treatment is eligible CS Healthcare will issue a Pre-Authorisation Certificate confirming the extent of cover available.
When invoices for treatment are received they will be settled directly with your provider. We will contact you to advise you of any co-payment or excess amount you will need to settle directly.
If you require further treatment, you must contact CS Healthcare to obtain further Pre-Authorisation before proceeding.
Please Note:
On occasion we may need further information to confirm that this claim does not relate to a pre-existing condition. If this is the case it may be necessary to speak to a member of our underwriting team who may request that you send us copies of medical reports or documentation about the treatment you are claiming for.

When you contact the Claims Helpline to make a claim on your policy we will ask you to provide the following information:

- your policy number
- what condition the claimant is suffering from
- has the claimant claimed for this condition previously
- your claim number (only if you have claimed for this condition previously)
- when the symptoms first began
- the date on which the GP was first seen for this condition
- has the GP made a referral to a Consultant, further investigations or for treatment
- the name of the Consultant to which a referral has been made.

We will then talk you through the cover available under your policy, and will guide you on what you need to do next.

What happens if you have more than one insurance policy and/or a cash plan?

You must tell the Society if you think any of the cost of your claims can be claimed from any other insurance policy that you hold.

If the other policy is an indemnity policy:

- If we settle your claim first, we will contact the other insurer for their share of the claim.
- If the other insurer settles the claim first, we will settle our share of the claim directly with the other insurer.

We shall not be liable to pay or contribute more than our proportionate share between the insuring parties for any benefits covered under several plans.

If the other policy is a cash plan:

- We will pay the benefits available to you available under your policy
- You may also be able to claim any expenses due from your cash plan

What happens if you are also claiming against a third party?

If you are claiming against a third party, for compensation as a result of a Road Traffic Accident or other claim, and have claimed medical expenses from us:

- you must tell us
- we will write to your Solicitor giving details of the medical expenses for which you have claimed, asking them to include the cost of these expenses in your claim with the third party, if appropriate
- if your case is successful and compensation is paid (whether in full or part settlement) you will need to pay our outlay to us. In the event of part-settlement you will need to pay us the percentage of medical expenses costs recovered
- you (or your Solicitor) must keep us informed about the progress and outcome of any claim.

Settlement of invoices

CS Healthcare will settle its share of treatment costs on your behalf. We will inform you in writing of the payment made and any outstanding amounts for you to pay. Any balance due will normally be in respect of a co-payment, an excess, or shortfall on an invoice.

Payment of invoices will only be settled with the provider on acceptance of a valid claim and receipt of a fully completed Claim Form.

Most hospitals will submit invoices directly; however, you may receive invoices from your Specialist or other service provider. Please forward all such invoices to us (ensuring that they are the originals) and they will be settled directly in accordance with the terms and conditions of your policy. It is recommended that you keep a copy of any invoice sent to you or your own records.

In the event that you are required to pay at the time of your treatment, you should send the receipted invoice to us and we will reimburse you accordingly.

How to Claim under the Cash Benefits option

To receive any of the Dental, Optical and Health Screening benefits you will need to complete a Claim Form that we will provide. To request a Claim Form, please call 020 8410 0440^.

When making a claim, you will need to send us the completed Claim Form and attach your original receipts. In addition if you are claiming Health Screening benefit you will need to get the registered Physician to stamp your Claim Form.

Your PMI cover for long-term treatment / Chronic Condition(s)

What is a long-term chronic condition?

The **your choice** policy does not cover treatment of a long-term chronic condition (please refer to S2 Chronic or Long-term Conditions on page 28). Your policy defines a chronic medical condition as: a disease, illness or injury which 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.

The long-term chronic rule does not apply to Cancer conditions and the related care required to treat them (more information can be found on page 28)

What does this mean in practice?

When you make a claim for a new condition, firstly we need to establish that the claim is eligible under your policy terms, i.e. that it is not excluded as a General or Specific Exclusion (as per pages 26 and 28) or by a personal exclusion detailed on your Registration Certificate.

Once we have established that the claim can be covered our aim is to provide cover to diagnose, treat and stabilise the condition in the short-term. Cover for a condition will not continue indefinitely and payment for treatment will stop at a given point.

If you select one of our limited benefit options: Expert Diagnostics 1000/Expert Diagnostics 500/Heart & Cancer Limited (this will be confirmed on your Registration Certificate), you have a set amount of money to claim, therefore if your treatment exceeds the amount of funds you have available you will have to change your care to the NHS or you may continue to fund your treatment yourself.

There are many different types of long-term Chronic Conditions, and we recognise that treatments and circumstances may change and new treatments may become available to offer a cure and individual care needs vary from person to person. In most cases we will cover the consultations and tests, which may include an admission to hospital, to diagnose and stabilise the condition. Individual treatment plans detailing a patient's condition may be requested so we can make a full assessment of the patient's needs and give guidance on what cover will be available to you.

However, treatment and ongoing consultations to maintain and provide relief of symptoms will not be covered on an ongoing basis and we will inform you when you need to discuss with your supervising Consultant when to switch your care to the NHS or you may continue to fund your treatment yourself.

The following are examples of the extent of cover we will provide for Chronic Conditions:

If you have a personal exclusion applied to your policy covering Diabetes, or if Diabetes is deemed a pre-existing condition under moratorium terms, we will not pay for the treatment of: Diabetes, Ischaemic heart disease, Cataract, Diabetic retinopathy, Diabetic renal disease, Arterial disease or Stroke.

If you have a personal exclusion applied to your policy covering Raised blood pressure (hypertension), or if Raised blood pressure (hypertension) is deemed a pre-existing condition under moratorium terms, we will not pay for the treatment of Raised blood pressure (hypertension), Ischaemic heart disease, Stroke or Hypertensive renal failure.

If you have a personal exclusion applied to your policy covering Prostate Specific Antigen (PSA) tests, monitoring or treatment, or if Prostate Specific Antigen (PSA) tests, monitoring or treatment is deemed a pre-existing condition under moratorium terms, we will not pay for the treatment of any disorder of the prostate.

What if your condition gets worse?

If your chronic long term condition gets worse, this may be treated as an Acute Flare Up, we would ask for the details of the current situation and if it were confirmed that your current needs were acute and different from your usual symptoms and treatment needs, and is not for the purpose to review your state of health or medications, we would authorise a short course of treatment to bring your condition back under control.

In some instances long term control or relief of symptoms cannot be achieved and cover will be withdrawn. We will seek to advise you at the time of authorisation or on receipt of your treatment plan what cover will be available to you, in order that arrangements for future NHS or self fund care can be made.

If your Acute Flare Up required Emergency Treatment you would not be covered (See 'Emergency Treatment' definition on page 42).

Here are some examples of long term chronic conditions and how we will manage them:

EXAMPLE 1 – ANGINA:

Alan has been insured by CS Healthcare for many years. He develops chest pains and is referred by his GP to a specialist. He has a number of investigations and is diagnosed as suffering from a heart condition called angina.

Alan is placed on medications to control his symptoms.

Will Alan be covered?
To claim for the initial consultation and investigations of symptoms of chest pain Alan will need to have selected cover under one of the Expert Diagnostics options. Once a diagnosis of angina has been confirmed Alan will need to have selected one of the Heart and Cancer options to continue his claim. Providing he has selected these options and subject to his policy terms and limits, he would be covered for the initial consultations and investigations into his chest pain. He would also be covered for a further consultation to confirm diagnosis from the results of the tests and for the consultant to commence him on medication. Once the diagnosis of angina has been confirmed and he has successfully started on medication, we would cover one further follow-up consultation before care would need to be transferred back to the NHS.

What if the situation gets worse?
Two years later Alan's chest pain recurs more severely and his specialist recommends that he has a heart by-pass operation.

We would cover the heart by-pass surgery and all his associated care required. This would include pre and post operative consultations, tests and cardiac rehab for up to a year following his surgery (again this is subject to Alan having the Heart and Cancer option as part of his **your choice** policy). Ongoing monitoring of the heart condition will need to be transferred to the care of the NHS or self funded thereafter.

EXAMPLE 2 – ASTHMA:

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

Will Eve be covered?
To claim for the initial investigations and subsequent treatment of the Asthma, Eve will need to have selected cover under one of the Expert Diagnostic options. Providing she has selected an option and subject to her policy terms and limits, she would be covered for the initial consultations and investigations into her breathing difficulties. She would also be covered for a further consultation to confirm diagnosis from the results of her tests and for the consultant to commence her on medication. Once the diagnosis of Asthma has been confirmed and she has been successfully started on her medication, we would cover one further follow-up consultation before care would need to be transferred back to the NHS.

What if the situation gets worse?
Eighteen months later, Eve has a bad asthma attack.

Will Eve be covered?
Eve's Asthma attack would be considered an Acute Flare Up, and would require Emergency Treatment which is not covered under the policy (See 'Emergency Treatment' definition on page 42). If following her discharge from hospital her Consultant wished to see her for one private follow up consultation this would be covered. Ongoing monitoring of her symptoms would need to be managed by the NHS. In the event that asthma attacks requiring hospital admissions and then requiring consultant follow-ups became a feature of her illness, there would be no further cover available.

EXAMPLE 3 – DIABETES MELLITUS:

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

Will Deidre be covered?
To claim for the initial investigations and subsequent treatment of the diabetes Deidre will need to have selected cover under one of the Expert Diagnostics options. Providing she has selected an option and subject to her policy terms and limits, she would be covered for the initial consultations and investigations for the condition. She would also be covered for a further consultation to confirm diagnosis from the results of her tests and for the consultant to commence her on medication.

Deidre would also be covered for further consultations to allow for adjustments to her medication to be made while they aim to get good control of the condition. Once the Consultant has confirmed that good control has successfully been achieved, care would need to be transferred back to

the NHS. In some instances control of a condition may never successfully be achieved and in such circumstances cover will cease.

What if the situation gets worse?
One year later, Deidre's diabetes becomes unstable and her GP arranges for her to go into hospital for treatment.

Will Deidre be covered?
Deidre's unstable diabetes would be considered an Acute Flare Up, and would require emergency Treatment which is not covered under her policy (See 'Emergency Treatment' definition on page 42). However, if her diabetes had become unstable because of an underlying condition such as an infection, and her care was able to be given on a general ward environment and not in a critical care ward or emergency unit, then cover for a short term admission can be considered.
If following her discharge her Consultant wished to see her for one private follow-up consultation this would be covered. Ongoing monitoring of her symptoms would need to be managed by the NHS. In the event that the diabetes becomes poorly controlled with regular bouts of instability requiring hospital admissions and then these and associated consultant follow ups would not be covered.

EXAMPLE 4 – HIP PAIN:

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

Will Bob be covered?
To claim for the Osteopathy treatment of the hip pain Bob will need to have selected cover under the Therapy & Care option. Providing he has selected this option and subject to his policy terms and limits, he would be covered for the initial osteopathy appointment in the first instance, and then asked to contact us to confirm his future treatment needs. On confirmation of his treatment needs for the acute hip pain we would authorise the rest of the sessions recommended over the two-week period.

As the policy covers an Acute Flare Up and does not cover treatment to maintain or prevent symptoms, we would not cover the ongoing monthly appointments to prevent recurrence of his original symptoms, including ongoing pain relief. If Bob eventually needs a hip replacement then this would be covered under the Essential benefit.

Explaining the cover for Cancer
The **your choice** policy has a two options for cancer care, you can choose the Heart & Cancer Comprehensive option which gives you comprehensive cover for your Cancer treatment, providing you use a hospital from your chosen hospital list and that all costs are customary and reasonably charged. You can also choose the Heart & Cancer Limited option which has a lifetime benefit limit of £50,000 per heart and £50,000 per cancer condition, subject to policy rules.

As part of both Heart & Cancer options members may be entitled to benefit available under the **Your Care Package** (see page 17).
There may be occasions where the treatment you require will exceed the monetary amount available to you, the Your Care Package option may be beneficial in these circumstances.

EXAMPLE 1 – BREAST CANCER:

Beverley has been with CS Healthcare for five years when she is diagnosed with breast cancer. Following discussion with her specialists she decides:

- To have the tumour removed by surgery. As well as removing the tumour, Beverley's treatment will include a reconstruction operation
- to undergo a course of radiotherapy and chemotherapy
- to take hormone therapy tablets for several years after the chemotherapy has finished.

Will her policy cover this treatment plan, and are there any limits to the cover?
To claim for the treatment of breast cancer Beverley will need to have selected cover under one of the Heart & Cancer options. Providing she has one of these options and subject to her policy terms and limits she would be covered for:

- A surgical admission to remove the tumour
- Initial breast reconstruction, within five years of diagnosis
- Radiotherapy and Chemotherapy
- We will cover consultant supervision for 5 years; however, the hormone therapy will have to be provided via the NHS.

Please note that while the cover outlined is eligible under the Heart & Cancer Limited option, the monetary limit applied to this option may mean that not all aspects of the care can be covered and some aspects of it may need to be under the care of the NHS.

During the course of chemotherapy Beverley suffers from anaemia. Her resistance to infection is also greatly reduced. Her specialist admits Beverley to hospital for a blood transfusion to treat her anaemia

and prescribes a course of injections to boost her immune system.

Will her policy cover this treatment plan, and are there any limits to the cover?
CS Healthcare would cover the blood transfusion and also authorise the course of injections to boost her immune system.

Despite the injections to boost her immune system, Beverley develops an infection and is admitted to hospital for a course of antibiotics.

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

Beverley would be covered for the antibiotic therapy to treat the infection.

Five years after Beverley's treatment finishes the cancer returns. Unfortunately it has spread to other parts of her body. Her specialist has recommended a treatment plan:

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

The **your choice** cancer cover will provide cover for recurrence of cancer including if it has spread to other parts of the body, therefore she would be covered for:

- **The six cycles of chemotherapy**
- **The monthly infusions to strengthen the bones, to protect against pain and fracture, while the treatment is actively working and controlling the symptoms.**
- **The weekly infusions of a drug to suppress the growth of cancer, while the treatment is actively working and controlling the symptoms.**

Please note that while the cover outlined is eligible under the Heart & Cancer Limited option, the monetary limit applied to this option may mean that not all aspects of the care can be covered and some aspects of it may need to be under the care of the NHS. For instance, if you have your chemotherapy privately, this treatment may have used up your benefit.

EXAMPLE 2

David has been with CS Healthcare for 10 years when he is diagnosed with cancer. Following discussion with his specialist he decides to undergo a course of high dose chemotherapy, followed by a stem cell (sometimes called a 'bone marrow') transplant.

Will his policy cover this treatment plan, and are there any limits to the cover?
To claim for the treatment of cancer David will need to have selected the cover available under one of the Heart & Cancer options. Providing he has one of these options and subject to his policy terms and limits he would be covered for:

The course of high dose chemotherapy.

He will **not** be covered for the Stem Cell (Bone Marrow) Transplant, (please refer to policy exclusion on page 26).

When his treatment is finished, David's specialist tells him that his cancer is in remission. He would like him to have regular check-ups for the next five years to see whether the cancer has returned.

Will his policy cover this treatment plan, and are there any limits to the cover?
CS Healthcare would cover the regular check-ups with the consultant, including any associated investigations for the next 5 years.
Please note that while the cover outlined is eligible under the Heart and Cancer Limited option, the monetary limit applied to this option may mean that not all aspects of the care can be covered and some aspects of it may need to be under the care of the NHS.

EXAMPLE 3

Jenny has been diagnosed with cancer. Her policy has a limit and she decides to commence private treatment.

What help will be available if the policy limit is reached and she needs to transfer into the NHS?
From the outset of Jenny's care we would outline to her that a benefit limit applied to her policy, and that it was possible that not all of her required care could be covered. We would also explain the benefits of the **'Your Care package'.**

However, if she decided to have private care, we would request a treatment plan and then authorise each aspect of her care carefully, obtaining the costs as best as we can, and informing Jenny and her consultant, at the outset, if the costs of treatment were likely to exceed her benefit limit. We would also monitor any unexpected complications or changes in treatment which may result in the available benefit limit being used more quickly.

Right at the onset when assessing her treatment plan our Managed Care Team would seek to advise her and her consultant of exactly what elements of her care could be covered, we would further assess the benefit should a complication or variance in care occur which uses up the benefit faster than anticipated. Therefore giving prior warning on where and when her care will need to be transferred back to the NHS.

EXAMPLE 4

Eric would like to be admitted to a hospice for care aimed solely at relieving symptoms.

Will his policy cover this, and are there any limits to the cover?
Hospice Care is free for all Cancer patients whether private or NHS and our Managed Care Team would assist in helping access this care if required. In addition in recognition of the charitable status of the Hospice Care movement we will make a donation of £400 should this be requested.

Ongoing treatment for Drug therapy.
While we will cover you for take home drug therapy such as oral steroids, antibiotics and pain relieving medication during a course of drug therapy for either chemotherapy or treatment with biological therapies, to last up to 7 days from discharge, continued prescriptions of these should be requested from your NHS GP.

Out-patient prescriptions such as oral steroids, antibiotics and pain relieving medication and hormone therapies during period of necessary aftercare will also not be covered these can be supplied by your NHS GP.

For insured members with the Heart & Cancer Limited option there will be occasions where your treatment will exceed the benefit limits, and it may not be possible to keep funding a course of drug treatment, as outlined previously we would seek to help you make a choice regarding your cover and what treatments can be covered at the time of authorisation. However, in the event that you do choose to have all of your care privately and you have reached your £50,000 benefit limit the following options will be available to you.

- **Return to the NHS and receive the same treatment, if the drug is available.**
- **Return to the NHS and receive alternative treatment under the guidance of your Consultant.**
- **Pay for the treatment privately on a self-pay basis**

Claim Terms and Conditions

The Society will only consider a claim if:

- you have contacted the Claims Helpline on 020 8410 0440^ for pre-authorisation of your claim; (a pre-authorisation is valid for the date shown on the certificate. If your treatment is not taken or completed on this date you should contact the Claims Helpline to update us on your treatment plan and seek further pre-authorisation.) and
- the claim is being made through Essential or any other chosen option that you have which is valid at the time of your claim; and
- the condition or policy upgrade does not have a personal exclusion listed against it or qualifies under the Moratorium terms of your policy (please refer to 'General Policy Exclusions' section rule G4); and
- the condition or treatment is not stated as a policy exclusion (please refer to 'General Policy Exclusions' and 'Specific Exclusions and Advice' rule S3 for details); and
- your policy is current at the time that you receive treatment and there are no contribution arrears on the/your policy. Benefit will not be payable until the arrears have been cleared even if pre-authorisation has been given; and
- you and your insured dependant's, GP, Optical or Dental Practitioner has made the referral for opinion or treatment; and
- a fully completed Claim Form, has been submitted to us prior to the commencement of treatment; and
- we have been given all additional information requested, for you or for your insured dependants, from either a GP or your treating Consultant or from any person who has provided any of the treatment which is the subject of the claim; and
- Original invoices or receipts for treatment costs, or in the case of the NHS cash allowance confirmation of admission dates, are received no later than 1 year from date of treatment; and
- the claim is not fraudulent or reckless and the condition or symptoms for which you are claiming are not pre-existing whether you knowingly or mistakenly failed to disclose the information to us at the time of joining the Society (this includes occasions where we have pre-authorised a claim in good faith and it has later been brought to our attention that the subject of the claim was pre-existing or fraudulent); and
- all costs associated with the pre-authorised treatment are necessary and reasonably incurred, and that hospital costs are only incurred from a facility listed in your chosen part of the Directory of Hospitals, unless CS Healthcare has pre-authorised an alternative hospital. All Specialist/Consultant

Surgeon and Anaesthetist fees will be paid in full according to the rates of the CS Healthcare Fee Schedule (please refer to the medical fees section of our website www.cshealthcare.co.uk for full details or call the Claims Helpline on 020 8410 0440)^.

^ Calls to CS Healthcare will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

Surgeon and Anaesthetist Fees

Specialist/Consultants can legally charge a patient whatever they wish and while the majority will charge within our guidelines, a minority may not.

CS Healthcare will reimburse you the fees which we consider customary and reasonable, as per our Fee Schedule (please refer to the medical fees section of our website www.cshealthcare.co.uk for full details or call the Claims Helpline on 020 8410 0440^).

The maximum amount of fees we expect to pay for a procedure will be clearly detailed on your Pre-Authorisation Certificate; you may wish to discuss this with your Specialist/Consultant prior to your surgery.

A Specialist/Consultant will consider the agreement to treat a person as a contract between himself and the patient, and if they are unwilling to bill according to our customary and reasonable fees this could result in you having a shortfall which the Consultant will consider your responsibility. In the event that your treatment is more complicated than the procedure described on your Claim Form, we can consider an enhanced fee on receipt of a supporting letter from your Specialist/Consultant.

A Surgeon's Fee will cover the cost of the surgical procedure according to the relevant Clinical Classification and Schedule of Development (CCSD) code and complexity of the procedure.
It will also cover the period of post-operative supervision according to the average expected length of stay associated to the procedure. If an admission goes over the expected length of stay for a reason of medical necessity a further daily fee will be considered on submission of a medical update.

Where a Surgeon administers local anaesthesia or IV sedation AC100 we will also pay an additional fee to the main procedure.

Additional benefit will not be provided for CCSD codes that should not be billed together according to The Clinical Coding and Schedule Development Group.

Second Specialist/Consultant: if out of medical necessity there is the need for a second Specialist/Consultant to assist during a procedure, please contact the Managed Care Team for assistance.

Fees for a surgical assistant are not covered. If a second Specialist/Consultant is to be present during a theatre time to perform a separate procedure under the same anaesthetic then they will be reimbursed accordingly using the allocated CCSD code.

An Anaesthetist fee will cover the initial in-patient anaesthetic assessment, the cost of the anaesthetic including care in a critical care unit and pain relief within the first 24 hours directly following surgery. Should anaesthetic supervision be required following the initial 24 hour care in a Critical Care Unit, a further two days can be reimbursed for daily supervision.

Where it is necessary for an Anaesthetist to perform a pain relieving procedure in isolation (either outside the first post operative 24 hours or to treat an acute condition) they will be reimbursed in the same manner as we manage surgeons fees. Local anaesthesia or IV sedation (AC100) will be paid in addition to the main procedure.

Occasionally 'Standby' Fees are billed for Surgeons and Anaesthetists who may need to intervene in the event of an emergency. Where appropriate, these fees will be reimbursed according to the correct CCSD code.

Multiple Procedure Policy:

For a single procedure we will pay 100% of the customary and reasonable Surgeon and Anaesthetist fees according to CS Healthcare's Fee Schedule for the required CCSD Code and its recognised complexity.

If multiple procedures are carried out during one theatre admission, we will pay:

- Primary procedure – up to 100% of the listed fee price
- Second procedure – up to 50% of the second procedure in addition to the primary procedure
- Third procedure – up to 25% of the third procedure in addition to the primary and secondary procedure

No further benefit will be payable beyond the third procedure.

In the case that a procedure is performed bilaterally that cannot be billed under one CCSD code, benefit will be calculated in accordance with the above multiple procedures rule.

Maximum permitted fee amounts are clearly detailed on the Pre-Authorisation Certificate issued as confirmation of your level of cover. For further advice or to clarify a level of fee reimbursement please contact the Claims Helpline – 020 8410 0440^ alternatively you can use the CS Healthcare Fee Schedule available at www.cshealthcare.co.uk.

General Policy Exclusions

General Policy Exclusions describes particular terms which are excluded from your cover.

The Society will not cover

G1 Any benefit for a **your choice** option you have not chosen and are currently not paying a premium for cover.

G2 Any voluntary excess or co-payment shown on your Registration Certificate.

G3 Treatment and Medical costs: Any treatment in a hospital not on our lists or from the Extended list of the Directory of Hospitals when you have chosen the Partnership list.

The only time that we will consider treatment in a hospital not on our lists or listed as an Extended hospital when you do not have it as a policy option is if there is a particular treatment that is only available in one particular hospital or given by one particular Consultant, i.e. there is a need of medical necessity.

In the event that you choose to use a hospital not on our lists or in an Extended Hospital list instead of one from the Partnership list, we will pay up to the costs of an admission for a procedure or medical care in a hospital which would have been available to you. Any additional costs will be your responsibility. This benefit is referred to as the 'out of band hospital benefit'.

Any medical costs and Consultants fees, including Surgeon and Anaesthetist fees must be paid within the customary and reasonable terms. By this we mean that it should be within the expected average cost, and for a particular procedure listed within the CS Healthcare Fee Schedule be billed within our published levels of reimbursement. Please refer to section 'Surgeon and Anaesthetist fees' and/or our website at www.cshealthcare.co.uk for further details or call the Claims Helpline on 020 8410 0440^.

G4 Any condition or policy change which has a personal exclusion listed against it as described on your Registration Certificate will not be covered. In addition a non-disclosed condition, be it accidental or intentional will not be covered, this includes any fertility or reproductive conditions which are confirmed up and until the inception date of your policy.

G5 War, Terrorism and Contamination:
Any treatment for an illness or injury arising out of war, invasion, the act of a foreign enemy, hostilities (whether declared or not), civil war, riot, civil commotion, act of terrorism, rebellion, revolution, insurrection, or military or usurped power.

Any treatment required as a result of contamination with radiation and chemical or biological substances either in relation to the events listed directly above or as a result of an industrial accident.

G6 Treatment abroad/overseas for UK residents (by overseas we mean any country outside the United Kingdom). The Society will consider requests for treatment within the European Economic Area (EEA), in line with the S2 scheme or Article 56 of the European Community; if there is a medical need such as an unacceptable waiting period to receive treatment within the United Kingdom (UK) or if there is a particular need which requires an individual to have planned treatment within the EEA. This will be dependent on your UK based Specialist/Consultant having consented to the treatment as being appropriate and that you are fit to travel, then consideration to authorisation can be given.

The planned treatment will only ever be reimbursed up to the value of treatment of the same complexity and to the value of those charges which would have been incurred at a hospital as listed in the Directory of Hospitals. Consultants Fees will be paid in line with the CS Healthcare Fee Schedule. This will be subject to you pre-authorising your treatment and receiving a written offer of cover from CS Healthcare.

If you have planned NHS funded treatment within the EEA we will consider authorisation of the NHS cash allowance according to the average length of stay for a particular procedure had it been undertaken within the NHS in the United Kingdom, subject to any medical complications.

G7 Can I continue my policy if I go to live abroad?
Your policy provides cover for specific eligible treatment that takes place in the United Kingdom. It is important that you notify us in writing before you take up residence abroad and note that you may not be able to claim for treatment in your country of residence. You will not be covered for treatment that takes place outside the UK unless it has been arranged under the European Economic Area (EEA) reciprocal arrangements and we have agreed to the cover as specified in clause G6. For the purpose of living abroad the appropriate insurance policy to cover that country's health needs should be considered.

If you choose to keep your policy and return for

treatment to the United Kingdom, you will not be covered for any travel costs incurred to necessitate your return and you will also need to use a hospital from the Directory of Hospitals in line with your level of cover. Please refer to the Directory of Hospitals for more information. Should you return to the UK and use the policy for treatment it must be on the referral of a General Practitioner or an appropriate referring medical doctor from your country of residence. You should contact us for pre-authorisation of your claim before proceeding with treatment. If you do not have a General Practitioner in the United Kingdom, and incur private General Practitioner fees either in the United Kingdom or in your country of residence, you will not be able to claim these fees on your policy.

G8 Professional Sports:
Any illness or treatment resulting from an injury sustained as a result of taking part in a sport for which you are receiving a salary, monetary reimbursement including sponsorship or for which you regularly represent your country.

Specific Treatment Exclusions and Advice

Specific Exclusions give details of those particular conditions and related medical services which are **not** covered. For clarity, the aspects which are covered under the policy are detailed directly under each section.

The Society will not cover:

S1 Unlicensed/Experimental treatment:
What is not covered:

X Drugs which are not licensed and authorised by the Medicines and Healthcare products Regulatory Agency (MHRA).
X Any treatment being medical or surgical including the use of prosthesis, not based on established medical practice, or proven to be safe and effective, or been assessed by the National Institute for Health and Care Excellence (NICE).
X The cost associated with treating or correcting the direct complications of unproven or experimental treatment including unlicensed drugs in any circumstance.
X Consultations and investigations associated with the collection of trial data.

What is covered:

✓ Where there is an alternative 'conventional' treatment available which the Society would have covered; we will offer the level of reimbursement we would have paid for the hospital, Consultant and Anaesthetic Fees, as long as the patient/member has fully consented to the alternative experimental treatment, and understands that any direct complications of the experimental treatment will not be covered by the Society. Any extra costs may have to be paid by you.

S2 Chronic or Long-term Conditions:
What is not covered:

X Care of a condition which continues indefinitely and has no known cure.
X Care of recurrent symptoms which come back or are likely to come back.
X Care of a permanent condition, including congenital or birth defects.
X Care of a condition for which rehabilitation or specialist training is required to cope with it.
X Care of a condition which requires long-term and regular monitoring, consultations, check-ups, examinations and tests. The long-term administration of blood transfusions and Kidney Dialysis.
X Blood tests and monitoring of medications and changing of prescription drugs not associated with acute episodes.
X Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS) and any condition directly related or attributed to these conditions.
X Care of recurrent, relapsing and poorly controlled conditions and /or symptoms, requiring repeated and regular care

What is covered:

✓ Treatment of acute flare up of a chronic condition curable in the short term either by surgery or medical intervention which is proven safe and effective, and has been reviewed and assessed by NICE (National Institute for Health and Care Excellence).
✓ Diagnostic tests and consultations and treatment to stabilise symptoms of a newly diagnosed condition.
✓ Acute Flare Ups of a diagnosed chronic condition requiring a surgical or medical admission. This includes pre-authorised in-patient admissions to a general ward, but excludes Emergency Treatment (See 'Emergency Treatment' definition on page 42)

S3 Acute Conditions:
What is not covered:

X Recurrent, relapsing and poorly controlled conditions and or symptoms as defined under Acute Flare Up
X Emergency Treatment (See 'Emergency Treatment' definition on page 42).
X Any acute condition covered by a Personal Exclusion or by the Moratorium terms of your policy. See 'General Policy Exclusion' rule G4.
X Long-term stays in a Critical Care Setting.

X Organ transplants, including artificial organs and ventricular assist devices, and the aftercare, maintenance and related complications of having received a transplant or any treatment related to having been an organ donor.
X Preparation and/or treatment for the recovery and transplantation of bone marrow and autologous bone marrow/stem cell transplantation and related complications of having received a transplant or being a donor
X Illness or injury arising through contamination with radioactivity.
X Bariatric Surgery including related advice and counselling.

What is covered:

✓ Pre-authorised treatment of an Acute Flare Up
✓ Pre-authorised treatment in your hospital choice of Partnership or Extended as listed in the Directory of Hospital (please see 'General Policy Exclusion' rule G3).
✓ Care in a Critical Care unit only when associated with a pre-authorised surgical admission (operation) or medical stay for an acute phase of treatment.

S4 Pregnancy:

Pregnancy is generally not covered under this scheme:

What is not covered:

X Any pre-natal/antenatal care is not covered including the treatment of pre-eclampsia, eclampsia, placenta praevia and foetal scanning.
X Any fertility treatment, including secondary fertility treatment and investigations of recurrent miscarriage are not covered, unless an underlying medical cause requiring surgical treatment is identified and the details are submitted from the treating Consultant to CS Healthcare for our consideration.
X Any labour either spontaneous or planned is not covered; including a ventouse and forcep deliveries.
X Emergency Caesarean Sections for any medical reason.
X Neonatal Care
X Foetal Surgery and Blood Transfusion.
X Intentional termination, (abortion).
X Congenital or birth defects.
X Routine post natal care and consultations and investigations.

What is covered:

A pregnancy confirmed after the inception date of your policy will be covered for the following:

✓ A planned Caesarean Section that is required for a reason of medical necessity, of which the details have been submitted from the treating Consultant, to CS Healthcare for our consideration, or transfer to a private ward following an emergency caesarean section provided no critical care is required.
✓ Planned removal of an Ectopic Pregnancy (pregnancy outside the womb).
✓ Planned treatment of a Hydatidiform Mole (molar pregnancy).
✓ Evacuation of retained products of the womb following miscarriage or pregnancy.
✓ Induction of abortion for foetal abnormality.
✓ Insertion of a Shirodkar or Purse string suture for an incompetent cervix.
✓ Complications of any of the above and any medical complications requiring stabilisation following delivery, excluding treatment in a Critical Care Unit.
✓ Post Natal follow up by a Specialist/Consultant within the terms of the 90 days necessary aftercare following an authorised procedure.

S5 Dental Treatment:

Dental treatment is generally not covered under this scheme:

What is not covered:

X Any routine dental treatment including the cost of providing and fitting dental appliances, and treatments such as root canal, crowns and dental implants.
X Any orthodontic treatment including the cost of providing and fitting braces and other related appliances.
X Any periodontal treatment including the care and treatment of gum disease.
X Any cosmetic dentistry including teeth whitening for any reason.
X The cost of a Dental Surgeon to complete a Claim Form.

Please note: The above applies with the exception of those benefits available under the Cash Benefits option.

What is covered:

Pre-authorised treatment by a Dental or Oral Facial Maxillary Surgeon in a Surgical Dental Centre or a hospital listed in our Directory of Hospitals where sedation or general anaesthetic is required for one of the following:

✓ Hospitalisation for dental treatment where anti-coagulant therapy requires management is covered under the policy terms.
✓ Surgical removal of impacted/buried tooth/teeth.
✓ Surgical removal of complicated buried roots.
✓ Surgical drainage of a dental abscess.
✓ Surgical removal of a jaw cyst or tumours including malignancy.
✓ Treatment of facial fractures also described as mandibular, zygomatic or maxillary fractures; including internal or external fixation.

✓ Surgical treatment for Temporo-Mandibular Joint (TMJ) Dysfunction.

S6 Cosmetic and Lifestyle Treatment:
Cosmetic and Lifestyle Treatment is generally not covered under the scheme:

What is not covered:

X Surgical removal of any non diseased body tissue or part for preventative measures; and non acute conditions, including if there is a family history of cancer or for psychological reasons.
X Cosmetic or aesthetic treatment and surgery including for psychological reasons.
X Weight loss (Bariatric Surgery) like gastric banding or gastric bypass including advice and counselling.
X Breast Reduction Surgery for any reason.
X Restorative or cosmetic care for pre-existing conditions or as a result of surgery or accidents not previously covered by us.
X Surgical correction, including laser, of short or long sightedness including corrective lens implants, treatment of astigmatisms, correction of refractive errors and replacement lenses secondary to sight corrective surgery.
X Speech Therapy for non medical conditions.
X Sex change (gender reassignment) for any reason, including the related medical and psychological treatment.
X Birth Control, including sterilisation, vasectomy and insertion of Intrauterine Devices (IUD's).
X Sexual Dysfunction (including Erectile Dysfunction).
X Treatment in a Health Hydro, Health Farm, Spa or Clinic and Rehabilitation centre or any form of respite care, and in-patient stays for domestic reasons which are not related to a medical need, even if the facility is registered as a private hospital.
X The treatment of snoring and the related symptoms and the condition of Sleep Apnoea; including Continuous Positive Airway Pressure (CPAP) treatment or the like and any form Uvulaplasty.
X Treatment of Sexually Transmitted Diseases.

What is covered:

✓ The initial reconstructive Surgery following previous treatment for a malignant condition which was covered by us (including a claim for NHS cash allowance) under Heart & Cancer option; for example breast reconstruction following a mastectomy for breast cancer within the 5 year necessary aftercare terms.
✓ Reconstructive Surgery following a traumatic accident which occurred while you have a current policy with CS Healthcare.
✓ Correction of post-operative complications and infection which require plastic surgery for a condition which was covered by CS Healthcare under either the Essential or Heart & Cancer option.

S7 Psychiatry & Out-patient Counselling:
There is limited cover for this type of treatment under Expert Diagnostics Comprehensive option.

What is not covered:

X Day or In-patient care in a psychiatric hospital or clinic.
X Treatment for alcoholism, solvent and drug abuse or any addictive condition, including associated medical conditions.
X Treatment for eating disorders.
X Self-inflicted illness, injury or disability or associated medical conditions.

What is covered:

✓ Out-patient Psychiatric Consultations and Counselling under the care of either a Consultant Psychiatrist or Psychotherapist or a recognised Counsellor.
✓ Out-patient assessment by a Neuro-psychiatrist or Psychotherapist to aid the diagnosis of certain neurological conditions such as Parkinson's Disease or Alzheimer's Disease.

Always check the credentials of your practitioner before incurring any medical expenses. You are covered to see:
Consultant Psychiatrist or Psychotherapist who holds or has held a substantive NHS post or holds a certificate of Higher Specialist Training in these given specialities issued by the Royal College of Psychiatry or the General Medical Council in accordance with EU directives or a Counsellor or Psychotherapist registered with the British Association for Counselling & Psychotherapy.

S8 Out-patient Services; Drugs, Appliances and GP:

What is not covered:

X Any benefits listed in the Expert Diagnostics option and the Therapy & Care option, if you have not chosen it as an option and are not currently paying a premium for it.
X Appliances and Aids not directly associated with the benefits under the Therapy & Care option.
X Treatment that has fallen outside the 90 day Necessary aftercare terms of the Essential option.
X Treatments that have fallen outside the 1 or 5 year necessary aftercare terms under the Heart & Cancer option.
X Emergency Treatment (See 'Emergency Treatment' definition on page 42)
X Emergency/urgent domiciliary visits by a Specialist/Consultant.

X The reimbursement of private medical fees for a General Practitioner (GP) any other medical practitioner, *Dentist and *Optician (*Unless covered under the Cash Benefits options). In addition referral letters and medical reports from GPs and other medical practitioners who are family members are not accepted in support of a claim.
X The cost associated with the completion of a Claim Form or medical report.
X The cost of cancellation and non attendance fees for out-patient appointments.
X The cost of telephone or any other electronic media related Consultation, including the collection of results.
X Out-patient drugs except chemotherapy drugs (medicines), dressings and nutritional supplements. Take home drugs are not covered with the exception of up to a 7 day course being provided on discharge following an admission for chemotherapy or biological therapies. A Heart & Cancer option would be required to claim under this.
X Hormone Replacement Therapy (HRT), including treatment for the menopause.
X The general maintenance of foot conditions like corns, hard skin, and toenail maintenance.
X The cost of assessing, fitting and providing an external prosthesis, hearing aid (including cochlear implants) and spectacles/contact lenses (unless you are covered under the Cash Benefits option).
X Assessment and treatment of learning, behavioural and developmental difficulties or special educational needs including, but not limited to, Autism and Autism Spectrum Disorders, Attention Deficit Hyperactivity Disorder (ADHD) Dyslexia and Dyspraxia; and congenital and growth disorders.
X Preventative treatment, Health Screening (unless you are covered under the Cash Benefits option) and vaccinations.
X Genetic testing/Preventative screening.
X Maintenance therapy.

What is covered:

✓ Any benefits listed in the Expert Diagnostics option and the Therapy & Care option, if you have chosen it as an option and are currently paying a premium for it. Please refer to the 'Expert Diagnostics' and 'Therapy & Care schedule of benefits' – within this Policy Document for a full list of benefits.
✓ Necessary aftercare within 90 days of surgery or a medical admission as available under Essential.
✓ Necessary aftercare within 1 year of a cardiac procedure or
✓ Necessary aftercare following the initial date of the primary diagnosis of cancer for a maximum of 5 consecutive years under the Heart & Cancer option.
✓ Allergy assessment when undertaken by a Consultant holding an appointment at an NHS Allergy Clinic or a Consultant recognised by the British Society for Allergy and Clinical Immunology. (Find a Clinic at www.bsaci.org or call the Allergy UK Helpline at 01322 619898).

Policy Administration

Joining

The minimum age for a policy holder to join CS Healthcare is 18 years and the maximum age to join is 74 years and 11 months.

Dependants can be included on the policy at the time you join. Dependants can be added or removed from the policy at a later date providing at least 15 days notice has been provided in order to process your request. Changes will be effective from the following month of cover. New born children can be added, without any evidence of health, provided they are registered within two months of birth. However, it is important to note that treatment for the purposes of, or related to, any neonatal care or surgery commencing within three months of delivery will not be covered (please refer to 'Specific Treatment Exclusions and Advice' section rule S4 within this Policy Document). The first born child on the policy will not have to pay premiums until the renewal following their 18th birthday. No premium will be payable for any subsequent child until the renewal date after their 1st birthday. Children may remain on the Member's policy until the renewal immediately following their 25th birthday. At this time we will write to both the Member and adult dependant to explain the change and to invite the adult dependant to join the Society in their own right.

The Society may impose special terms on an individual membership including, but not limited to, exclusions of specific medical conditions, restrictions on particular benefits, discounts or surcharges on the contribution rates. Any such special terms will be confirmed in writing by the Society at the time of registration, renewal or transfer.

In some instances we may require additional information from either a GP or other health professional who is involved in your treatment or care, any expense incurred for this will have to be covered by you.

The Society may also apply underwriting terms in form of a six month (or longer) wait period where appropriate. This means that you may not be able to use the benefits from your chosen scheme change immediately.

Switching your health insurance to CS Healthcare

If you are already insured by an existing insurer, you may be able to switch your health insurance provided you have been insured within the last **60 days** prior to joining. Please refer to 'Switching your health insurance to CS Healthcare' section on page 37 for the terms and conditions.

Renewing

The period of each policy is one year from the effective date shown on the Registration Certificate. At the end of that time your policy will automatically renew on the same terms (unless you advise us otherwise in writing or by telephone), for another year if the plan is still being offered.

We will write to advise you of any changes to your policy within a reasonable time-frame before your renewal date

At the date of your renewal, or at the discretion of the Society, you can write to us or telephone and request to increase your level of cover, remove or reduce an excess or co-payment, or move to a different plan. The Society may accept or refuse any request to increase cover. If your request is accepted, we will make the change effective from your renewal date and adjust your premiums appropriately. All personal exclusions which are listed on the policy will remain in place.

Increasing cover – adding options/removing or decreasing an excess/changing choice of hospital band

Examples of increases in cover include:

- moving from Expert Diagnostics 500 to Expert Diagnostics 1000,
- adding another option to your current health insurance cover,
- or decreasing an excess.

If you wish to increase your cover please contact the Membership Services Team on 020 8410 0400^ at least 15 days before your renewal date.

Please note, requests to increase in cover may be refused or accepted by the Society. Accepted requests may also be subject to new underwriting terms. If this is the case, we will write to you to advise you of these restrictions so that you have the opportunity to reconsider your decision to increase cover.

To increase cover on the Cash Benefits option, for example a move from Level 1 to Level 2, please contact the Membership Services Team on 020 8410 0400^ at least 15 days before your renewal date. As this change is effective from the renewal of your policy no additional qualifying period will apply i.e. claims up to the new benefit limit can be applied for without any additional waiting period.

IMPORTANT NOTE: Increases in cover can only be made at renewal with notification being given to the Membership Services Team at least 15 days before your renewal date. Notification must be received in writing or by telephone and it is the responsibility of the member to ensure the Society has received this notification. If accepted, changes will be effective from the next renewal date.

Reducing cover or cancelling particular options from your policy

A reduction in cover includes:

- taking out or increasing a voluntary excess,
- moving from Expert Diagnostics Comprehensive to Expert Diagnostics 1000 or Expert Diagnostics 500,
- moving from Heart & Cancer Comprehensive to a Heart & Cancer Limited (a £50,000 limit for each Heart condition and an additional £50,000 for each Cancer condition),

Reducing cover – Expert Diagnostics and Heart & Cancer

Expert Diagnostics

If you reduce your cover mid-year and move from Expert Diagnostics Comprehensive to either Expert Diagnostics 500 or Expert Diagnostics 1000, or, from Expert Diagnostics 1000 to Expert Diagnostics 500, your claims history for that year will be carried forward once the changes to your cover have been made.

For example, say you had chosen Expert Diagnostics 1000 and your policy year runs from January to January and a claim totalling £200 is made in March on Expert Diagnostics. In July you decide to reduce your cover to Expert Diagnostics 500. You will then have £300 worth of benefit left for the remainder of that policy year. If you had already exceeded your limit for the year, there would be no benefit remaining for that policy year.

Please note: If you reduce your cover at renewal a new benefit limit is applicable per person per policy year.

Heart & Cancer

If you reduce your cover from Heart & Cancer Comprehensive to Heart & Cancer Limited, your previous claims history (per condition for a heart or cancer claim) will be carried forward once the changes to your cover have been made.

For example, Heart & Cancer Limited gives you a £50,000 limit for heart and an additional £50,000

for cancer. If you had made a claim worth £30,000 during your entire membership for a cancer condition on Heart & Cancer Comprehensive, you would be allocated a £20,000 benefit limit for that condition for the remaining lifetime of your membership. If you had already exceeded the limit for the condition, there would be no benefit remaining for the condition. Please note, any future requests to increase cover will be underwritten.

NB. You cannot have both an excess and a co-payment on your policy. If you wish to cancel options (excluding Essential) from your policy and/or increase your excess or co-payment option please contact the Membership Services Team on 020 8410 0400^ providing at least 15 days notice. Details of the contributions for each of these options are shown on the Registration Certificate. Please refer to the 'Voluntary Excess and Co-payment Options' section within this Policy Document for information as to how the excess and co-payment work.

IMPORTANT NOTE: Reduction in cover can be made at any time providing at least 15 days notice has been provided in order to process your request. Notification must be received in writing or by telephone and it is the responsibility of the member to ensure the Society has received this notification. Changes will be effective from the following month of cover. Please note that policy Terms and Conditions following a reduction in cover will reflect those available to members at the time of the change. We will inform you of any changes to the Terms and Conditions of your policy when administering your request.

Death of policyholder

On the death of a Member, any dependant held on the deceased's health insurance policy shall have that cover extended without payment of contributions for the period up until the next policy renewal date.

If premiums are paid annually, premiums will be

refunded on a pro-rata basis for whole months only (if applicable).

If the member dies the policy will automatically be transferred to the oldest insured person over the age of 18 years who shall become the main policyholder for the purposes of this policy and be responsible for paying the premiums.

Cancellation of a policy (of Essential and whole policy)

New members (and those renewing) may cancel membership within 15 days of receiving their policy documentation, or 15 days from the commencement or policy renewal, and a full refund will be given provided that no claims for benefit have been submitted during the policy year. If you wish to cancel your membership you must notify the Society in writing or by telephone.

Members may cancel their policy at any other time by notifying us in writing or by telephone. It is the responsibility of the member to ensure the Society has received this notification. Monthly premium payments will cease from the next instalment date, provided at least 15 days notice has been given. If premiums are paid annually, they will be refunded on a pro-rata basis for whole months only (if applicable), less any pre-payment or introductory discount.

If you choose to cancel your membership, you may re-register on the same terms and conditions within 30 days. Membership must be continuous, so any premiums that would have fallen due within the 30 days will need to be paid in full before your policy can be re- instated. After this 30 day period you may re-apply to be a member of CS Healthcare but will be required to be re-underwritten (see 'Re-joining' section of this document).

Re-joining

Any person wishing to re-join the Society may apply to do so. Neither you nor your dependants will have an automatic right to re-register with us, or an automatic right to re-register on the same policy terms and conditions on which you were previously a member. Your application may be made subject to further underwriting.

Voluntary excess and co-payment options

The following excess and co-payment options are available:

- £100 Excess.
- £300 Excess.
- Co-Payment Option £1000.
- £500 Excess.
- Co-Payment Option £3000.
- £1000 Excess.
- £2000 Excess.

If you have chosen a voluntary excess on your policy, the amount of this excess will apply to each person for each policy year for admissible claims made across the following options:

- Essential
- Expert Diagnostics Comprehensive
- Expert Diagnostics 1000

- Expert Diagnostics 500
- Heart & Cancer Comprehensive
- Heart & Cancer Limited

NB. An Excess is not applied to the Therapy & Care or Cash Benefits option.

This means that you and each dependant on your policy will be liable for the chosen excess level for any claims made for each person (insured) on the policy during the policy year. Whilst eligible invoices will be accepted against the excess, a payment will not be made until the cost of eligible treatment in any policy year exceeds the monetary value of the excess.

Example One – Claims (within the same policy year) on Expert Diagnostics Comprehensive where a policyholder has selected a £500 excess

1st Invoice
Total of Invoice: £80

Application of Excess: £80 accepted and applied against excess

Payment settled by CSH: Nil

Excess Balance: £420

2nd Invoice
Total of Invoice: £520

Application of Excess: £520 accepted £420 applied against excess balance

Payment settled by CSH: £100

Excess Balance: Nil

3rd Invoice
Total of Invoice: £110

Application of Excess: £110 accepted Nil applied against excess

Payment settled by CSH: £110

Excess Balance: Nil

Example Two – Claims (within the same policy year) where a policyholder has a £500 excess on their policy and claims are made on the following cover options

- Essential
- Expert Diagnostics Comprehensive
- Therapy & Care
- Heart & Cancer Comprehensive

1st Invoice - Expert Diagnostics Comprehensive
Total of Invoice: £80

Application of Excess: £80 accepted and applied against excess

Payment settled by CSH: Nil

Excess Balance: £420

2nd Invoice - Essential
Total of Invoice: £320

Application of Excess: £320 accepted £320 applied against excess balance

Payment settled by CSH: Nil

Excess Balance: £100

3rd Invoice - Therapy & Care
Total of Invoice: £200

Application of Excess: £200 accepted Excess does not apply to Therapy & Care option

Payment settled by CSH: £200

Excess Balance: £100

4th Invoice - Heart & Cancer Comprehensive
Total of Invoice: £700

Application of Excess: £700 accepted £100 applied against excess

Payment settled by CSH: £600

Excess Balance: Nil

Examples where an excess applies to a module with monetary limit

Where an excess is applied to an option with a monetary limit, the amount of the claim where approved will count towards your benefit limit and accepted against your excess as if we had paid the claim in full.

Example Three – For claims (within the same policy year) on Expert Diagnostic 1000 and a £300 excess exists on the policy:

1st Invoice
Total of Invoice: £80

Application of Excess: £80 approved and applied against excess and benefit

Payment settled by CSH: Nil

Excess Balance: £220

Balance of Benefit Limit: £920

2nd Invoice
Total of Invoice: £520

Application of Excess: £520 approved £220 applied against excess balance

Payment settled by CSH: £300

Excess Balance: Nil

Balance of Benefit Limit: £400

3rd Invoice
Total of Invoice: £110

Application of Excess: £110 approved Nil to apply

against excess balance

Payment settled by CSH: £110

Excess Balance: Nil

Balance of Benefit Limit: £290

Example Four – Claims (within the same policy year) where a policyholder has a £300 excess on their policy and claims are made over the following cover options:

- Essential
- Expert Diagnostics 1000
- Therapy & Care
- Heart & Cancer Comprehensive

1st Invoice - Expert Diagnostics 1000
Total of Invoice: £80

Application of Excess: £80 approved against excess and benefit limit

Payment settled by CSH: Nil

Excess Balance: £220

Balance of Benefit Limit: £920

2nd Invoice - Essential
Total of Invoice: £320

Application of Excess: £320 approved £220 applied against excess

Payment settled by CSH: £100

Excess Balance: Nil

Balance of Benefit Limit: N/A

3rd Invoice - Therapy & Care e.g. physiotherapy
Total of Invoice: £200

Application of Excess: £200 accepted excess does not apply to Therapy & Care option
Payment settled by CSH: £200

Excess Balance: Nil

Balance of Benefit Limit: N/A

4th Invoice - Expert Diagnostics 1000
Total of Invoice: £1200

Application of Excess: £1200 approved
Payment settled by CSH: £920

Excess Balance: Nil

Balance of Benefit Limit: Benefit limit for Expert Diagnostics 1000 reached Member shortfall £280

5th Invoice - Heart & Cancer
Total of Invoice: £700

Application of Excess: £700 approved
Payment settled by CSH: £700

Excess Balance: Nil

Balance of Benefit Limit: N/A

For all authorised claims

Once you have received treatment, send any bills you receive to us - unless these have already been sent to us directly.

We will settle the balance of the claim (less any amount covered by your excess), advise you that payment has been made and let you know whether you should settle the excess amount with the hospital or with the Consultant.

The excess starts again at the beginning of each new policy year, even if treatment is on-going. Where treatment starts in one policy year and continues to the next the excess will apply again.

Important Note If claims overlap two policy years (or more) any excess or benefit limits would need to apply again.

Co-payment – applicable to Essential, Expert Diagnostics and Heart & Cancer options

If you have selected a co-payment on your policy, you have agreed to pay 15% of all eligible treatment across any of the following options up to a specific co-payment limit. Once the co-payment limit is exceeded, we will pay the cost of your claim in full (subject to any monetary limit applicable to the option selected).

- Essential
- Expert Diagnostics Comprehensive
- Expert Diagnostics 1000
- Expert Diagnostics 500
- Heart & Cancer Comprehensive
- Heart & Cancer Limited

The co-payment is applied to each insured individual on your policy for any claims made over a policy year. There are 2 levels of co-payment limits:

- £1000 co-payment
- £3000 co-payment

Example for £1000 co-payment option

1st Invoice - (Essential Benefits)
Total of Invoice: £5000

15% co-payment: £750

Amount allocated to co-payment: £750

Amount Settled: £4250

Balance of co-payment Limit: £250

2nd Invoice - (Essential Benefits)
Total of Invoice: £6000

15% co-payment: £900

Amount allocated to co-payment: £250

Amount Settled: £5750

Balance of co-payment Limit: £0

Example for £3000 co-payment option

1st Invoice - (Essential Benefits)
Total of Invoice: £9000

15% co-payment: £1350

Amount allocated to co-payment: £1350

Amount Settled: £7650

Balance of co-payment Limit: £1650

2nd Invoice - (Essential Benefits)
Total of Invoice: £2500

15% co-payment: £375

Amount allocated to co-payment: £375

Amount Settled: £2125

Balance of co-payment Limit: £1275

3rd Invoice - (Heart & Cancer Option)
Total of Invoice: £10000

15% co-payment: £1500

Amount allocated to co-payment: £1275

Amount Settled: £8725

Balance of co-payment Limit: £0

Example for £3000 co-payment limit where claim also made on a benefit limited option e.g. Expert Diagnostics 1000

1st Invoice - (Essential Benefits)
Total of Invoice: £9000

15% co-payment: £1350

Benefit Limit: No Limit

Amount allocated to co-payment: £1350

Amount Settled: £7650

Balance of co-payment Limit: £1650

Member Liability: £1350

2nd Invoice - (Essential Benefits)
Total of Invoice: £10500

15% co-payment: £1575

Benefit Limit: No Limit

Amount allocated to co-payment: £1575

Amount Settled: £8925

Balance of co-payment Limit: £75

Member Liability: £1575

3rd Invoice - (Expert Diagnostic 1000)
Total of Invoice: £1500

15% co-payment: £225

Benefit Limit: £1000

Amount allocated to co-payment: £75

Amount Settled: £925

Balance of co-payment Limit: £0

Member Liability: £575*

***The £575 member liability in this example consists of £75 co-payment balance, plus the £500 shortfall due to the £1000 benefit limit on their Expert Diagnostic 1000 option.**

NB. A co-payment is not applied to the Therapy & Care Option

Understanding Your Underwriting Options

Underwriting is the process by which an insurer decides on what terms it will accept a person for cover based on the information they supply. This section is designed to explain the underwriting methods by which you can apply for cover, so that you can decide the one that best suits your requirements.

When applying for cover with CS Healthcare you must answer all of the proposal form questions as fully and as accurately as you can, to the best of your knowledge and belief. Failure to do so may mean that subsequent claims made under the policy are declined, or may even mean that the policy is cancelled.

Depending on the **your choice** modules you have selected and the terms of insurance offered to you by CS Healthcare, the **your choice** policy may provide cover for initial investigations needed to diagnose a new condition and the initial short term treatment up to the point of stabilisation. However, it will not provide cover for medical conditions that keep coming back, or are likely to continue, and/or need regular or periodic monitoring, treatment, medication or medical advice.

The **your choice** policy is designed to work alongside, not to replace all the services offered by the NHS and in all cases customers retain the right to use the NHS.

When applying to join CS Healthcare the following methods of underwriting are available to you:

Full Medical Underwriting
If you choose this option, you will be asked a number of questions about your health. These will enable us to understand your medical history (and that of any dependant whom you wish to insure). It is important that you consider the questions carefully, for each person to be covered, and answer them fully. We will review your details and inform you of the terms of insurance we are prepared to offer. If necessary, we may need to ask your doctor for further information to help us to do this, if this is

the case you will be liable for any costs associated with obtaining this.

If you have a pre-existing condition that may need treatment in the future, we will usually exclude it from the cover along with any conditions related to it. We will show any personal exclusion on the Registration Certificate you receive from us when we have processed your application. The same process will also apply for any dependants included in your application.

IMPORTANT NOTE: If you or any dependant covered under the policy make a claim for symptoms that initially occurred within the first year of your policy, we will ask you to provide a copy of the GP referral letter so we can assess of the claim. This is to ensure we received all the correct information regarding the insured individual's state of health when they joined us.

Why some customers choose Full Medical Underwriting

Although this the Full Medical Underwriting option involves more of your time at the point of completing your application, it does mean that new eligible medical conditions that arise after the start of your policy will usually be covered immediately, subject to the policy terms and conditions. If you need to make a claim under a Full Medical Underwriting policy we will usually be able to authorise any required treatment over the phone.

Review of Personal Exclusions

You may ask us to review a personal exclusion, this is usually after two full years of membership or sooner if indicated on your Registration Certificate. There are some circumstances where we may be able to amend your underwriting terms for certain conditions. For us to consider removal of a personal exclusion we will require a medical report from your General Practitioner (GP), or medical practitioner confirming that the condition was cured, by which we mean that you have no active signs and symptoms, and you are not requiring regular medication or medical supervision. If you wish us to consider the removal of a condition, you should contact us before obtaining a report from your GP. If your GP makes a charge for issuing a medical report, this cost must be met by you.

It is important to understand that some medical conditions may never be reviewed. Of course, any new medical conditions arising after the start of your policy will be covered immediately subject to the policy terms and conditions.

Moratorium Underwriting

If you choose this option you do not need to fill in a health questionnaire. Instead we will automatically exclude the cost of treating any pre-existing conditions, or any condition related to it for which you (or any dependant included in your application) have received treatment and or medication, asked advice on, or had symptoms of (whether diagnosed or otherwise), during the 5 years immediately before your private medical insurance commences.

If you do not have symptoms, treatment, medication or advice for those pre-existing conditions, and any directly related conditions, for two continuous years after your policy starts, then we will reinstate cover for those conditions.

You should not delay seeking medical advice or treatment for a pre-existing condition simply to obtain cover under your policy.

IMPORTANT NOTES: At the point of every claim under a Moratorium policy, and before any treatment can be authorised, your General Practitioner (GP) will be required to submit a copy of the referral letter so that we can confirm if the condition is new or pre-existing. This procedure is continuous throughout the life of the policy. Your GP may charge you for this service.

Why some customers choose Moratorium Underwriting

If you choose this option you will only be asked to provide basic information about you and any dependants you wish to insure. You will not be asked to disclose details of your medical history, but you must understand that if you have any pre-existing conditions these will be excluded from cover unless you have completed a two year continuous period free from symptoms, treatment, medication or advice from those pre-existing conditions after your policy starts.

Switching your Private Medical Insurance to CS Healthcare

The intention of our switch terms is to allow those with current or recent private medical insurance to join CS Healthcare, in most cases, with the same method of underwriting as their previous insurer.

If you wish to apply for switch terms you will be asked a number of questions about your health. These will enable us to understand certain information about your medical history (and that of any dependant whom you wish to insure). **It is important to understand that there are certain types of treatment and pre-existing medical conditions which may mean that you do not qualify CS Healthcare's switch terms.** These conditions are outlined within the switch

underwriting section of the **your choice** proposal form, and include (but are not limited to) conditions such as stroke, cancer and joint replacements.

It is important that you consider the questions carefully, for each person to be covered, and answer them fully. Our underwriters will review the content

of the completed switch proposal form and advise you whether you are eligible for CS Healthcare's switch underwriting terms. If necessary, we may need to ask your doctor for further information to help us to do this, if this is the case you will be liable for any costs associated with obtaining this.

In order to qualify for switch terms you and any dependant included on the policy must also:

- Currently be insured under a UK private medical insurance policy, or have had a policy of this kind which expired within 60 days of your requested start date with CS Healthcare.
- Be a maximum age of 74 years and 11 months at the proposed start date of the policy.
- Provide a copy of the most recent insurance certificates of insurance for each dependant applying for switch terms.

Please Note: we will be unable to validate cover or authorise any claims for benefit until we have received and reviewed your previous certificate of insurance. Additionally, if valid certificates are not received within 60 days of commencing your policy, cover will be terminated by CS Healthcare.

A premium loading may be applied to any accepted 'switch' policy to reflect the additional risk to the Society and, if so, this will be shown on the Registration Certificate.

It is possible for a switch policy to include dependants who are not eligible for switch terms, providing that the main applicant qualifies for switch. Those dependants that are not eligible for switch will need to complete the relevant section of the **your choice** proposal form to select their chosen underwriting type. CS Healthcare will then advise the main applicant of the terms of insurance it is prepared to offer for all individuals included within the proposal form.

If you do not qualify for our switch underwriting terms you will be able to apply for either Full Medical Underwriting or Moratorium underwriting terms.

CS Healthcare offers the following switch underwriting terms:

Continued Personal Medical Exclusion (CPME)
CPME is a method of underwriting which may allow individuals who are currently insured with another provider to switch cover to CS Healthcare. With CPME terms you carry the current personal medical exclusions which apply to your existing policy across to a new policy with CS Healthcare. Eligibility for CPME terms will depend on the answers provided to some medical questions at application stage. We will also require a copy of your previous provider's medical insurance certificate as part of the application process.

Those individuals who qualify for switch terms and intend to switch to CS Healthcare from a Full Medical Underwriting, or a Continued Personal Medical Exclusions policy, will be offered CS Healthcare CPME terms.

Continued Moratorium (CM)
This option is designed to continue the date the original Moratorium period became effective provided no symptoms have occurred or that no treatment, medication or advice has been received during this period. Under Continued Moratorium we will automatically exclude pre-existing conditions for which you (and any dependant on the application) have received treatment for , taken medication for, asked advice on, or had symptoms of (whether or not diagnosed) during the five years immediately before your original moratorium start date.

However, if you do not have any symptoms, treatment, medication or advice (from your GP, a healthcare professional or a specialist) for those pre-existing conditions, and any directly related conditions, for two continuous years after your original moratorium start date, then we will reinstate cover for those conditions. Any new, unexpected eligible conditions arising after the start of your CS Healthcare policy will be covered immediately, subject to policy rules.

IMPORTANT NOTES: At the point of every claim, and before any treatment can be authorised, your General Practitioner (GP) will be required to submit a copy of the referral letter so that we can confirm if the condition is new or pre-existing. This procedure is continuous throughout the life of the policy. Your GP may charge you for this service.

Policy Rules

Membership terms
The terms of membership are set out in the current versions of the following documents all of which must be read together.

- any application form the Society asked you to complete
- Policy Document and Benefit Schedules
- Registration Certificate and letter of acceptance

- Directory of Hospitals
- Memorandum of Association & Rules
- any other document setting out information affecting the rights and obligations of the Society and you concerning membership.

These policies confer no financial interest in the Society except for the benefits they describe.

Premium payments

Premium payments can be paid annually or monthly in advance on the policy inception date and each time your policy renews.

The Society will determine the amount of the premium payable at the start of each policy year and will advise you within a reasonable time-frame.

We can increase or reduce the premiums you pay at any time if there is an increase or decrease in the rate of Insurance Premium Tax or any other government or statutory change, existing or introduced. If we do so we will only increase the premiums you have to pay to cover the cost to us of the changes in the taxes or charges. We will write to you at least 21 days before increasing your premiums.

How to make a complaint

The Society makes every effort to ensure that members are satisfied with the level of service we provide. However, if things do go wrong we have an open and fair complaints procedure. In the event that you are unhappy with our service, please contact us to explain the reason for your dissatisfaction:

Write to:
Civil Service Healthcare Society Limited,
Princess House, Horace Road,
Kingston upon Thames,
Surrey, KT1 2SL

Telephone the Membership Services Team on 020 8410 0400^

We will investigate your complaint and provide you with a written response. If you are unhappy with the outcome of our investigation you may refer the matter to the Financial Ombudsman Service.

Their contact details are:
The Financial Ombudsman Service,
Exchange Tower,
London E14 9SR
Telephone: 0300 123 9 123
E-mail: complaint.info@financial-ombudsman.org.uk

The complaints procedure is set out in Rule 41 of the Society's Memorandum of Association & Rules. Our complaints procedure is without prejudice to your right to take legal proceedings.

We are covered by the Financial Services Compensation Scheme, and you may be entitled to compensation from the scheme if we are unable to meet our obligations to you. The maximum level of compensation for valid claims with the Terms & Conditions of your policy is 90% of the claim, with no upper limit. Further information about compensation arrangements are available from:

The Financial Services Compensation Scheme
10th Floor, Beaufort House
15 St Botolph Street,
London EC3A 7QU
Telephone: 0800 6781100 or 020 7741 4100

Our Privacy Policy

Confidentiality

The confidentiality of patient and member information is of paramount importance to CS Healthcare. To this end we fully comply with General Data Protection Regulation (GDPR) and Medical Confidentiality Guidelines.

Types of data CS Healthcare may hold about you

Personal data

Personal data is any information relating to an identifiable person who can be directly or indirectly identified in particular by reference to an identifier.

Special category data

Special category data is personal data which the GDPR says is more sensitive, and so needs more protection, such as, medical history.

Keeping your data secure

We are committed to keeping your personal information secure. We have put in place physical, electronic and operational procedures intended to safeguard and secure the information we collect. This was certified by the Cyber Essential Plus accreditation achieved in 2016. All CS Healthcare staff have a legal duty to respect the confidentiality of your data, and access to your confidential information is restricted only to those who have a reasonable need to access it.

Legal basis for using your data

Contractual Consent - In becoming a member of CS Healthcare you have contractually agreed to CS Healthcare processing your personal data and special category data for the administration of your policy, including highlighting any member benefits that may be available to you. The processing will include (but is not limited to) passing information to third parties but only where this is necessary for the administration of your policy.

Where you are the main policyholder you are also

confirming that you have sought and agreed to act on behalf of any other person included within the policy. As such all membership documents and confirmation of how we have dealt with any claim(s) (including medical information) under the policy will be sent to you.

If you do not agree to the above terms, we will not be able to administer your policy and therefore cover will have to cease upon your request to no longer process your data in this way.

Consent to marketing and/or newsletters

We will only contact you only where you have consented for us to do so for:

- CS Healthcare's (care) newsletters by email or post;
- CS Healthcare's newsletters by email or post;
- CS Healthcare marketing, including offers, products and services;
- marketing from selected third parties about products and services you may be interested in.

You can unsubscribe from any of the above at any time by using the "unsubscribe" link at the bottom of each email or by contacting us on the details under the "Unsubscribing from marketing" section. We will only contact you on the contact preferences you have selected.

Collecting your data

Data about you is collected when:

- you apply for a quote or policy either online, by phone, via the post, an event or through a broker
- health checks (anonymised data for research purposes)
- you enter into a contract with CS Healthcare for the provision of private medical insurance and when you use those services
- you submit a query to us, for example by email, telephone or social media.
- you consent to marketing from CS Healthcare. We may also collect personal data about you from a policy holder when you are named on an application form and where the policy holder has confirmed they are acting on your behalf.
- we process an application or claim (where we may carry out fraud checks), or when we obtain medical reports from health professionals/providers
- in accordance with the Access to Medical Records Act, when you have agreed for us to access your medical information from your treating consultant or provider
- you are not in a position to offer the information yourself but would like to make use of the policy's services e.g. if you havebeen admitted to hospital under the NHS and would like someone to discuss a possible transfer to a private hospital on your behalf (CS Healthcare will look to verify the request by subsequently contacting the associated providers and health professionals).
- where you have opted in to CS Healthcare's services via your employer or its broker.

Data we may hold about you

The data we hold about you may include the following:

- contact information such as name, address, email
- broker referral and quote information
- medical information such as claims experience/history and related information
- information about complaints, incidents and feedback regarding CS Healthcare and providers associated with your treatment
- notes and reports about your health and any treatment and care you have received or need, including about clinic and hospital visits and medicines administered
- information from customer surveys, competitions and marketing activities
- recordings of calls we receive or make
- other information we receive from other sources, including cookies, IP addresses and social media posts

Processing your data

We may process your data to provide you with our services, and to improve and extend our services. By "processing" we mean CS Healthcare remains the controller on the data, this may include:

- responding to your queries, including providing quotes
- communicating with consultants and providers
- internal record keeping and administration
- responding to requests where we have a legal or regulatory obligation to do so
- checking the accuracy of information about you, and the quality of your treatment or care, including auditing medical and billing information for insurance claims
- assessing the type and quality of care you have received and any concerns or complaints you raise, so that these can be properly investigated
- using your contact information to send you service related information
- where your consent has been given, we may use

your contact information to send promotional material about new products, special offers or other information we think you may find interesting (see 'Keeping you informed' below for more information)

- using your contact information to give you an opportunity to complete a customer satisfaction survey
- using your information for the purpose of market research
- outsourcers/suppliers CS Healthcare uses for the administration of your policy (further information available upon request)
- using data in an anonymous format with companies we work with, such as, auditors and actuaries for data security, analysis and business purposes

Sharing information

Information about you may be shared by CS Healthcare, by "sharing" we mean providing a copy of information for another party to use for their own purposes

We do not share your personal information with anyone outside of CS Healthcare, except:

- when you have requested for us to do so
- when we are permitted or obliged to do so by law. For example, if we are required to provide information to organisations such as the National Registries (e.g. The Cancer Registry) and the government regarding certain infectious diseases such as tuberculousis and meningitis (but not HIV/AIDS)
- if we are under a duty to disclose or share personal data in order to enforce or apply our terms of use (of our website or any part of it) or terms and conditions of supply of any relevant products or services and other agreements
- to protect the rights, property, or safety of CS Healthcare, our customers, or others in order to detect, prevent and help with the prosecution of financial crime. For example, we may share information with fraud prevention or law enforcement agencies, and other organisations. If we suspect fraudulent activity, we may inform the person or organisation who administers or funds your CS Healthcare services.
- if there are other exceptional circumstances, and we are unable or it is not appropriate to seek your permission.

In rare circumstances, the processing & sharing of your personal information may take place outside of the European Economic Area in countries with different data protection laws. In that case we ensure that the confidentiality and security of your personal information is protected the same way as EU law.

In the event that we (or any member(s) of our group) sell or buy any business or assets, we may disclose your anonymised personal data to the prospective seller or buyer of such business or assets. However, if there is a requirement to provide non-anonymised data we will seek your consent beforehand.

Data Retention

CS Healthcare reserves the right to retain your personal data for the length of time you have an active policy. Following termination of your policy we reserve the right to retain your information for up to 7 years.

There are a number of exceptions where CS Healthcare may retain your information for longer than 7 years, these are:

- for the prevention and detection of fraud, only where there are reasonable grounds to do so. In addition, we work collectively with other organisations to share information relating to fraudulent/ suspicious claims. If you would like further information as to these third parties, please write to the Data Protection Officer
- for financial reporting and our actuarial function but only in an anonymised format
- for management information to support the Society's strategic objectives but only in an anonymised format

Your Rights

Right to be Informed

You have the right to be informed about the collection and use of your personal data which we will undertake following a request. We will also ensure you are notified prior to the collection of any personal data from other sources.

Right of access

You are entitled to request a copy of the information we hold about you. In most cases we will aim to provide information without the need for a formal request to be made. However, if you require all of your information or a significant amount this may take up to 30 days and in some circumstances longer but only where the request is highly complex to fulfil (you will be notified if we require more time).

Right to data portability

You have the right to receive your information (under right of access and

informed) in a clear, understandable manner and in an electronic format.

Right to be forgotten
You have the right to request for CS Healthcare to remove all information about you. However, such a request can only be considered where you are no longer a member of the Society, as we will be unable to administer your policy. We do reserve the right to refuse a request but we will clearly explain our legal basis to retain the information if it is necessary for us to do so.

Right to erasure
You have the right to request for CS Healthcare to remove all information about you. However, such a request can only be considered where you are no longer a member of the Society, as we will be unable to administer your policy. We do reserve the right refuse a request but we will clearly explain our legal basis to retain the information if it is necessary for us to do so.

Right to rectification
You have the right to contact CS Healthcare and ask that any incorrect data we hold on you be rectified. You may be required to provide evidence of error before it can be rectified. All such requests may take up to 30 days and where the request is more complex this may be extended further by up to 60 days.

Right to restrict processing
You have the right to request that CS Healthcare restrict the processing your data, e.g. if you no longer wish to receive marketing you can change your marketing preferences. However, some data restrictions may impact our ability to offer our services.

Right to object
You have the right to request that CS Healthcare cease to process your data in a certain way. If you feel that CS Healthcare is processing your information in a way which you do not consider appropriate you can ask us to stop. However, such a request may impact our ability to offer our services.

Right not to be subject to automated decision-making including profiling
CS Healthcare does not currently use any data for automated decision making and profiling, however, in the event that the Society adopts this method we will ensure it is highlighted and your consent is sought beforehand.

Accessing information
If you have any queries about your data that remain unanswered please contact the CS Healthcare Data Protection Officer:

Email: DataEnquiry@cshealthcare.co.uk

Write: Data Protection Officer, CS Healthcare, Princess House, Horace Road, Kingston-Upon-Thames, KT1 2SL

Information Commissioner's Office
If you do not feel that CS Healthcare has adequately addressed yours concerns following your referral to our Data Protection Officer, you can seek further guidance and information from the Information Commissioners Office:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF
Website: https://ico.org.uk/
Email: casework@ico.org.uk
Telephone: 0303 123 1113

Unsubscribing from marketing
CS Healthcare will only send you marketing information relevant to you, where you have consented for us to do so. You have the right to opt out of marketing consent at any time and you can do this by using the unsubscribe link on any recent marketing emails or by contacting us by telephone or email on the contact details below:

Email: info@cshealthcare.co.uk
Phone: 0208 410 0400
Address:
Civil Service Healthcare Society Limited,
Princess House, Horace Road,
Kingston upon Thames, Surrey, KT1 2SL.

Telephone calls
Calls to CS Healthcare will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

Regulation
CS Healthcare is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

Our Financial Services Register number is 205346. Our permitted business is to provide private health insurance contracts. You can check this on the Financial Services Register by visiting the FCA's website at www.fca.org.uk/register or by contacting the FCA on 0800 111 6768.

Please note that any reference to "CS Healthcare" within the pages of this document shall be taken to mean "Civil Service Healthcare Society Limited" unless otherwise indicated.

Access to Medical Reports Act (1988):
Sometimes we need to get a medical report from a

doctor who has cared for you before we can make a decision on your claim. The Access to Medical Reports Act (1988) gives you certain legal rights which are:

- we need your agreement before we can apply for a medical report from your doctor. You can refuse but if you do we will not be able to assess your application
- you can ask to see the report before your doctor sends it to us, or for up to 6 months after. If you wish to see the report, please tick the relevant box on the Access to Medical Reports Form in the Proposal Form to indicate you want to see the report. This may delay the assessment of your application and your doctor can charge you a reasonable fee to cover costs
- if you think a part of the report is incorrect or misleading when you see it, you can ask your doctor to have it changed
- if your doctor will not agree to do this, you may attach a statement of your own.

You will not be entitled to see any part of the report which:

- the doctor believes could seriously harm your physical or mental health, or that of others
- indicates the doctor's intentions in respect of you
- reveals information about another person, or the identity of someone who has giventhe doctor information about you (unless that person consents or is a health professional involved in caring for you).

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

Definitions

The words and phrases set out below have special meanings.

Accommodation
The charge made by the hospital for in-patient or day-patient treatment which includes the cost of the bed, meals, routine nursing and housekeeping.

Acute Flare Up
We mean an acute worsening or sudden deterioration of a previously diagnosed long-term chronic condition likely to respond to treatment in the short-term, this does not include the care for recurrent, relapsing and poorly controlled conditions and or symptoms or the monitoring of your state of health or review of your medications.

Acute Medical Condition/Acute
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
The items listed under each available **your choice** option for which you can claim the reimbursement of medical costs or receive a daily cash sum for an NHS stay in an acute general hospital.

Benefits schedule
The schedule of benefits of your chosen plan showing the maximum benefits we will pay for each insured person. This is also known as Schedule D.

Cancer
A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissue; and for the purpose of claiming under the Heart & Cancer option any brain tumour requiring surgery or chemotherapy or radiotherapy.

Chronic Medical Condition (long-term)/Chronic
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.

Claim
The benefits a member asks us to pay in respect of treatment for an eligible condition.

Continued Moratorium (CM)
A method of underwriting that is designed to continue the date of the original Moratorium period from your previous insurer.

Convalescence Care
The care required to recuperate from either a surgical or non surgical (medical) in-patient admission, in a registered care/ nursing home (registered with the Care Quality Commission) following a patient's immediate discharge from hospital.

Co-payment
The 15% of medical expenses, which you have agreed to pay towards the cost of all eligible treatment, subject to the limit of either £1000 or £3000 per person per policy year.

Continued Personal Medical Exclusions (CPME)
A method of underwriting where CS Healthcare may continue any personal medical exclusion applied by their previous insurer – any new conditions that are awaiting surgery or diagnosis that have arisen whilst being insured will be re-underwritten.

Critical Care
Treatment given in either a resuscitation room, intensive care or high dependency unit, including coronary care units, which requires the specialist care, supervision and support by intensive care specialists.

Customary and Reasonable
Your benefits state that you are 'Covered'. By this we mean that all costs must be necessary, customary and reasonably incurred at a hospital from the appropriate part of the Directory of Hospitals or as previously agreed by us, and that all Surgeon and Anaesthetist fees will be paid in full according to the rates of the CS Healthcare fee schedule. All other incurred cost must be within average and acceptable levels appropriate for the services provided.

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

Dental, Orthodontic and Periodontal procedures
The following procedures are covered under your policy provided the treatment is carried out as a medical necessity under general anaesthetic, by a Dental or Facial Maxillary Surgeon practising in a hospital included in our Directory of Hospitals:

- Surgical removal of impacted/buried tooth/teeth.
- Surgical removal of complicated buried roots.
- Surgical drainage of dental abscess.
- Enucleation of cyst of jaw.
- Treatment of mandibular, zygomatic or maxillary fractures including internal or external fixation.
- Excision or resection of mandible or maxilla, including removal of malignancy.
- Maxillary osteotomy and prosthetic surgery.
- Open operations of the jaw including the temporo-mandibular joint.
- Hospitalisation for dental treatment where anti-coagulant therapy requires management.

Dependant
Your legal or civil partner including married and separated couples and your natural children, legally adopted children, partner's children or stepchildren or children where you are the legal guardian. All children must be under the age of 25. This does not include a person living with you or any other members of your family, no matter how long the period.

Diagnostic tests
Investigations, such as X-rays, blood tests and ECG to find or to help to find the cause of your symptoms.

Directory of Hospitals
The document published by the Society which lists the Partnership or Extended hospitals whose charges have been agreed with the Society and you may use subject to which hospital option you have chosen. Partnership will cover you for a wide choice of provincial hospitals and a selection of London Hospitals. Extended will cover you for the central London Hospitals.

Emergency treatment
An admission to:

- a hospital directly following an accident, or
- a hospital ward directly from the emergency department for urgent or unplanned treatment, or
- a hospital ward on the same day as a referral for treatment is made either by a GP or specialist, when immediate treatment or diagnostic tests are necessary, or
- a hospital to receive immediate lifesaving surgery.

Excess
The amount of expenditure which you have agreed to pay each policy year towards the cost of eligible treatment for each person covered on the policy, in return for receiving a discount on your premiums.

Full Medical Underwriting (FMU)
A method of underwriting where you are asked to give details of your medical history.

General Practitioner (GP)
A medical practitioner holding the Certificate of Completion of Training (CCT) in general practice, who is registered with the General Medical Council and included on the GP Register.

Health Screening
Health Screening is defined as Wellwoman screening, and Wellman screening, Breast Cancer screening, Osteoporosis screening, Bowel Cancer screening, Cervical Screening and Executive Check-ups at a recognised screening centre under the care of a physician.

Home Help
A person who is registered by a Local Authority employed to do domestic chores; preparation of meal for persons unable to look after themselves adequately following an acute admission to hospital, but does not require personal care to assist with Acute Medical or nursing care.

In-patient treatment
A patient who is admitted to hospital and who occupies a bed overnight or longer for medical reasons.

Insured person
The member and any insured dependants for whom we are receiving a premium/payment for a CS Healthcare policy.

Managed Care Team
Our Managed Care Team assist with all cancer claims and other potentially complex claims in respect of some heart procedures and joint replacements. They also manage urgent hospital admissions and complications of planned treatment. The aim of the team is to ensure treatment is pre-authorised in a timely manner, policy terms and conditions are followed, and where there is a benefit limit to notify the member should that limit be reached.

Medical necessity
Diagnostic investigations and treatment including surgery that is required to cure, correct and stabilise an acute medical condition.

Medical practitioner
A person registered or whom the Society accepts as a medical practitioner. (Please refer to the Specialist/Consultant definition within this section).

Member
The policyholder with whom we have made the membership and who is responsible for paying the premiums for a CS Healthcare policy.

Moratorium
A method of underwriting offered at the time of joining where you do not declare any medical history. However, all pre-existing conditions or symptoms (whether diagnosed or not) which have been in existence during the 5 years immediately before your policy start date will not be covered until a 2 year period has passed where no symptoms treatment or medical supervision of any kind has been confirmed.

Necessary aftercare
Where you have chosen the Heart & Cancer option the period of necessary aftercare will continue subject to pre-authorisation for 1 year for cardiac conditions and for up to 5 years following the initial diagnosis for cancer conditions

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

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

Overseas
A country outside the United Kingdom.

Plan
The **your choice** health insurance plan is made up of the compulsory Essential cover and the additional Expert Diagnostic option, Therapy & Care option, Heart & Cancer option and Cash Benefits option. In addition there is a choice of hospital coverage from either the Partnership and Extended lists within the Directory of Hospitals.

Planned treatment
An admission to a hospital by means of a waiting list or direct consultant referral provided the admission does not take place on the same day as the referral/consultation.

Policy
The insurance contract between you and us, including the following documents which are sent to you from time to time:

- any application form the Society asked you to complete
- Policy Document and Benefit Schedules
- Registration Certificate and letter of acceptance
- Directory of Hospitals
- Memorandum of Association & Rules
- Contribution rates
- any other document setting out information affecting the rights and obligations of the Society and you concerning membership.

Pregnancy
CS Healthcare will cover the following complications of pregnancy under the policy:

- Caesarean delivery, where medically necessary
- Ectopic pregnancy
- Hydatidiform mole
- Evacuation of retained products of uterus following Miscarriage and childbirth
- Induction of abortion for foetal abnormality
- Insertion of Shirodkar suture.

Medical treatment is allowed where your Obstetrician identifies the need and as authorised by the Society, this does not include delivery room costs for a normal or induced labour or for prolonged periods of bed rest to monitor a pregnancy.

Pre-authorisation
Approval given either verbally or in writing by the Society prior to any treatment taking place, as a guarantee that we will meet your treatment costs as part of an eligible claim – providing you are still paying premiums for the appropriate **your choice** option at the time of treatment.

Pre-existing conditions
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 5 years before the start date of cover.

Prosthesis
A surgical appliance, such as a joint replacement and bone fixation, heart valve, pacemaker, stents, grafts and meshes, which are implanted by a Specialist/Consultant during a surgical procedure.

Related condition
Any symptom or condition, disease, illness or injury which is medically considered to be associated with another symptom or condition, disease, illness or injury will be considered as one claim.

Renewal date
Each anniversary of the commencement date of your membership as displayed on your Registration Certificate.

Routine monitoring
Regular consultations, check-ups, examinations or tests to assess your ongoing state of health.

Society
Civil Service Healthcare Society Limited.

Specialist/Consultant
A registered medical or dental practitioner who holds or has held a substantive NHS Consultant's post, or has a certificate of Higher Specialists Training in the relevant specialty issued by the appropriate Royal College and who holds a current General Medical Council Number and a current License to Practice; in accordance with EU medical directives.

Specialised scans
High cost scans such as: Nuclear Scans, PET Scans, Myelogram, Thallium Scans, DAT & MIBG Scans, Perfusion/Ventilation Scans.

Special terms
This refers to personal exclusions, general exclusions or conditions or restrictions to benefit which we may apply to your policy on joining, re-joining or transfer and which will be shown on your Registration Certificate.

Speech Therapy
Speech Therapy given after trauma, surgery or a cerebrovascular accident, under direction or recommendation of a Specialist/Consultant, by a therapist who is registered with the Health and Care Professions Council (HCPC).

Stable
Transfer to private care will only be considered once a patient is stable. By this we mean a patient is able to be nursed in a general ward setting and does not require critical care including resuscitation, intensive care, high dependency or coronary care, life support or immediate lifesaving surgery. Transfers from an Emergency department will not be covered

Surgical procedure
An operation including open incision and/or laparoscopic procedures, used to correct an injury, disease or degenerative change; and also including endoscopic procedures performed as a day case procedure required to aid a diagnosis or to give therapeutic relief of symptoms.

Switch
The terms under which we will transfer your cover from another health insurer provided you have been insured within the last 60 days prior to joining and transfer your current underwriting terms to CS Healthcare. The two methods by which you can do this are Continued Personal Medical Exclusions (CPME) or Continued Moratorium (CM).

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

Treatment Plan
A documented plan that describes the patient's condition detailing the treatment to be provided and expected outcome, including the duration of the treatment prescribed.

United Kingdom
England, Scotland, Wales, Northern Ireland, Channel Islands and Isle of Man.

We/Us/Our
Civil Service Healthcare Society Limited.

Year
The period of 12 calendar months from when the membership began or was last renewed. The policy year to which your benefits, co-payment or excess terms apply for each insured person.

You/Your
The member or any insured dependant.

Your Care Package
A tailor-made discretionary package of care, agreed in advance of treatment, for those members electing to receive all or part of their treatment on the NHS. Your Care Package is considered for in-patient treatment only and does not cover out-patient treatment (see page 17).

For requesting a Claim Form and pre-authorising treatment contact the Claims Helpline on

020 8410 0440^

claims@cshealthcare.co.uk

For general enquiries contact the Membership Services Team on

020 8410 0400^

membership@cshealthcare.co.uk

For 24 hour health advice contact Lifeline

020 8410 0415^

lifeline@healix.com

Find us on Facebook **Just search cs_healthcare**

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