YOUR POLICY BOOK

HEALTHPLAN SAVER PLUS, SAVER PLUS 4 WEEK WAIT AND SAVER PLUS 6 WEEK WAIT

SAGA

Experience is everything

CONTENTS

Section

Quick reference guide for important information

Saga HealthPlan Saver Plus, Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6 are underwritten by AXA PPP healthcare Limited, therefore any reference to 'we, us, our' in this document means AXA PPP healthcare.

Contacting us

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

You should always call our Claims Personal Advisers on the number provided before starting **treatment**. Please be aware that if you do not obtain authorisation from us before starting **treatment** then we may be unable to pay for the **treatment** you receive in full or in part.

To speak to a healthcare professional

Saga GP Service
0800 027 1333

(operated by HealthHero Solutions Limited)
Available day or night, 365 days a year. You can book an appointment online via www.saga.co.uk/GPService

Saga Health Information Line
0800 17 40 17

Available day or night, 365 days a year.

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

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

Claims Personal Advisory Team
0800 027 1331

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

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

Fax: 01179 726100

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

Manage your claim online

You can make a claim or pre-authorise **treatment** online at www.axahealth.co.uk/saga-login

You can also message us regarding a claim or view your claims documentation securely online.

To discuss or make changes to your Saga HealthPlan

Customer Care Team
0800 056 9273
Or call +44 2082 822946 from abroad

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

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

For example, our Claims Personal Advisory Team can be contacted by Next Generation Text on **18001 0800 027 1331** and the Saga Health Information Line can be contacted on **18001 0800 17 40 17**.

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

WELCOME TO SAGA HEALTHPLAN SAVER PLUS

Thank you for choosing a Saga HealthPlan underwritten by AXA PPP healthcare Limited. Saga aims to provide the highest level of care and service possible, so this policy has been designed with your needs in mind.

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

Please take the time to read this booklet carefully to make sure you fully understand what you are covered for, that your policy gives you the cover you want and that you are aware of the additional advice and support lines available to you as a Saga Health Insurance customer.

If you have any questions at all, feel free to call Saga's Customer Care Team on the relevant telephone number opposite and one of the team will be happy to help.

1 INTRODUCTION

The purpose of this Policy Book and how to use it

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

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

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

- the cover you have (both benefits and limitations);
- how to make a claim;
- how your **policy** is administered; and
- other services provided by your **policy**.

Throughout your Policy Book certain words and phrases appear in **bold type** to indicate they have a special medical or legal meaning. You will find a glossary of these words in section 13 or, if they apply to a specific section, they will be defined there.

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

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

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

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

2 YOUR COVER

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

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

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

The Saga HealthPlan Saver Plus, Saver Plus 4 and Saver Plus 6 policies offer you cover for necessary **treatment** of new **medical conditions** that arise after you join. They do not cover you for **treatment** of **medical conditions** that existed, or you had symptoms of, before joining. However, in some circumstances you may have joined on a different basis, please refer to section 5 'Existing medical conditions' for further information.

There is also no cover for ongoing, recurrent and long-term conditions (also known as **chronic conditions**).

Your cover includes:

- **in-patient** and **day-patient treatment** and associated **specialists'** charges
- **out-patient surgical procedures**
- radiotherapy and chemotherapy
- one computerised tomography (CT), magnetic resonance imaging (MRI) or positron emission tomography (PET) scan
- unlimited follow-up CT, MRI and PET scans performed within eight months after related, **eligible in-patient** or **day-patient treatment**, or after a related **eligible out-patient surgical procedure**
- up to £1,000 of benefits for **out-patient diagnostic tests**, **out-patient** consultations (including post-operative consultations), **therapists'**, **physiotherapists'**, **acupuncturists'** and **practitioners'** charges
- up to 28 days a **year** for **in-patient** and **day-patient** mental health **treatment**
- up to £1,500 of benefits a **year** for **out-patient** mental health **treatment**.

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

*With a '4 Week Wait' or '6 Week Wait' plan, if the NHS can give you the hospital **treatment** you need within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed, then you must use the NHS. For more information, please see the '**Benefits table**' section starting on page 5 and the 'Your cover for cancer treatment' section starting on page 20.*

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

This **policy** has a No Claim Discount scheme, which entitles you to a No Claim Discount provided you don't make a claim. Please see section 10 'Additional information' for details of how your No Claim Discount is calculated.

Be aware:

Your policy will not cover you for:	Where can I find more information?
Treatment of **medical conditions** that existed, or you had symptoms of, before joining (in some circumstances you may have joined on a different basis)	Section 5
Treatment of ongoing, recurrent and long-term conditions (**chronic conditions**)	Section 7
Dental procedures other than those included under the optional Health Cash Benefits Cover	Section 6
Routine pregnancy and childbirth	Section 6
*Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: Urgent or emergency **treatment***	*Section 4*
Charges when **treatment** is received outside of the **Saga Countrywide Hospital List** (unless the **treatment** has been approved by us in advance)	Section 8
Treatment that we have not first authorised as **eligible** for payment	Section 4

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

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

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

Please see section 8 'Who we pay for treatment and where you can be treated' (page 25) for full details.

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

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

Please see section 8 'Who we pay for treatment and where you can be treated' (page 27) for full details.

3 BENEFITS TABLE

The **benefits table** on page 6 shows the benefits available to you together with the monetary limits of your **policy**. These benefits are explained fully in this Policy Book. You must read this table in conjunction with the rest of your Policy Book.

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

Please note:
You should obtain authorisation for your claim from us before starting **treatment**. If we ask you to complete a claim form, you must send it to us for confirmation of your cover. If you do not, we may be unable to pay for the **treatment** you receive in full or in part. All **in-patient treatment** and **day-patient treatment** must also take place at a **hospital** listed in the **Saga Countrywide Hospital List**.

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

*If you have Saga HealthPlan Saver Plus 4 or Saga HealthPlan Saver Plus 6: This **policy** will cover the cost of **in-patient** or **day-patient treatment**, or a **surgical procedure** performed as **out-patient treatment**, if the NHS could not provide that **treatment** within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed. The only exceptions to this provision are shown in the following paragraph (Immediate cover) and radiotherapy or chemotherapy performed as **day-patient treatment** or **out-patient treatment**.*

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

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

*There is no benefit for urgent or emergency **treatment.***

Optional excess information

Excess for each person covered by these **policies** each **year** (as shown in your Policy Schedule):

Option 1:	£100
Option 2:	£250
Option 3:	£500
Option 4:	£750
Option 5:	£1,000

Excesses do not apply to the NHS cash benefit, the **external prosthesis** benefit, counselling arranged through Stronger Minds, consultations through the Saga GP Service, or the optional Health Cash Benefits Cover.

If you have chosen the optional Extended Cancer Cover, the excess does not apply to the hospital expenses cash benefit, purchase of wigs or other temporary head coverings or hospice donation.

Benefits	Amount payable	For more information
In patient and day-patient treatment		**Section**
1. **Hospital** charges: including charges for accommodation, **diagnostic tests**, operating theatre charges, nursing care, drugs and dressings, physiotherapy, and surgical appliances used by the **specialist** during surgery.	No annual maximum at a **hospital** listed in the **Saga Countrywide Hospital List** or a **hospital** we have chosen with you	8
2. **Specialists**' fees (surgeons, anaesthetists and physicians).	No annual maximum	8
3. **In-patient** consultations – benefit for a consultation with a second **specialist** arranged by the treating **specialist**.	No annual maximum	8
4. **Hospital** charges for mental health **treatment**, including charges for accommodation, **diagnostic tests** and drugs.	No annual maximum when such **treatment** is received at a **hospital** listed in the **Saga Countrywide Hospital List** or a **hospital** we have chosen with you, up to a total of 28 days a **year**	7
Out patient treatment		
5. **Surgical procedures**.	No annual maximum	6
6. **Specialist** consultations. 7. **Diagnostic tests** performed by your **specialist** or on **specialist** referral. 8. **Practitioner** and **physiotherapist** charges. 9. **Therapist** and **acupuncturist** charges.	These four benefits (6, 7, 8 and 9) have a combined overall limit of £1,000 a **year** This includes remote consultations by telephone or video link instead of you going to an **out-patient** clinic.	8
10. **Cancer treatment**. Including charges for radiotherapy (the use of radiation to treat **cancers**) and chemotherapy (the use of drugs to treat **cancers**). Please refer to 'Your cover for cancer treatment' in section 7.	No overall annual maximum (any **eligible out-patient treatment** that took place prior to or to establish a **cancer** diagnosis would affect the monetary limits detailed in benefits 6, 7, 8 and 9 above. However, any **eligible out-patient cancer treatment** costs following a **cancer** diagnosis are not subject to these monetary limits or the eight month requirement detailed in benefit 11(ii))	7
11. (i) One computerised tomography (CT), magnetic resonance imaging (MRI) or positron emission tomography (PET) scan per **year**. (ii) Unlimited follow-up CT, MRI or PET scans performed within eight months after related, **eligible in-patient** or **day-patient treatment**, or after a related **eligible out-patient surgical procedure**.	Paid in full in any **centre** listed in the **Saga Countrywide Hospital List** or a **scanning centre** we have chosen with you	8
12. **Specialist** consultations for mental health **treatment** and **diagnostic tests** performed by your **specialist** or on **specialist** referral.	Up to a maximum of £1,500 a **year** This includes remote consultations by telephone or video link instead of you going to an **out-patient** clinic.	7
13. Counselling sessions through Stronger Minds. Sessions with a counsellor when this is directed by, and arranged through, the Stronger Minds service. This could be face-to-face or telephone counselling. The type and amount of counselling will be arranged as clinically appropriate by the Stronger Minds service. Only counselling arranged through Stronger Minds is covered by your **policy**. Over 18s only.	Counselling is not subject to the maximum limit allowed for mental health **treatment** (shown in benefit 12 above)	4
Other benefits		
14. Nursing at home.	Paid in full for up to a total of 2 weeks when all of the following applies to **treatment**: • it is provided immediately after a period of **eligible in-patient treatment** • it is provided by a **nurse** under the direction of a **specialist** • it is skilled nursing care provided at your home • it is provided for at least 7 hours a day Please note: this benefit is not available following **in-patient** mental health **treatment**	8

Benefits	Amount payable	For more information
15. NHS cash benefit. This benefit is paid for each night you receive free **treatment** under the NHS when all of the following applies: (i) You are admitted for **in-patient treatment** before midnight (ii) The **treatment** you receive under the NHS would have been **eligible** for benefit privately under this **policy**. *Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: The four/six weeks waiting period does not apply to NHS cash benefits.* There is no requirement for private **treatment** to have preceded any period in an NHS intensive therapy unit or NHS intensive care unit.	£100 a night, up to £2,000 a **year**	8
16. **External prosthesis** benefit.	Up to £5,000 for the lifetime of your **policy**. We will pay this benefit towards the cost of providing an **external prosthesis**.	6
17. Saga Health Information Line. Confidential medical information.	Immediate access 24 hours a day, 365 days a **year**	11
18. Saga GP Service. Access to the confidential GP helpline is available in addition to your **policy**. You can book an appointment online via www.saga.co.uk/GPService	Immediate access 24 hours a day, 365 days a **year**	11
Health Cash Benefits Cover (optional cover) The following benefits only apply if you have opted for the Health Cash Benefits Cover and they are available to the policyholder and their spouse/partner only.		
19. Dental care.	Up to £200 per person covered a **year**	9
20. Optical care.	Up to £150 per person covered a **year**	9
21. Dental accident.	Up to £200 per person covered a **year**	9
22. Dental emergency.	Up to £200 per person covered a **year**	9
23. Health assessment.	Up to £150 per person covered a **year**	9
Extended Cancer Cover (optional cover) The following benefits are available if you have opted for the Extended Cancer Cover benefit and they are in addition to those shown in the Extended Cancer Cover table on page 23.		
24. Hospital expenses cash benefit. This benefit is paid out upon diagnosis of **cancer**.	Maximum £100 a **year**	7
25. Additional expenses incurred to support you whilst you are undergoing **active treatment of cancer**: (i) Purchase of wigs or other temporary head coverings (ii) Provision of external prostheses following surgical **treatment**.	Up to £400 a **year** Up to £5,000 a **year**	7
26. Hospice donation. This is a charitable donation to a registered hospice charity that is providing you with end of life care related to **cancer** either in a hospice or hospice at home.	£100 a night up to a maximum of £2,000 a **year**. This is a charitable donation paid direct to the registered hospice charity when you are provided free **treatment** in a hospice. £100 per day up to a maximum of £2,000 a **year**. This is a charitable donation paid direct to a registered hospice charity when you are provided free hospice at home care **treatment** in lieu of a residential hospice admission.	7

Please note:
If you have an excess on your **policy**, it will not be affected by the NHS cash benefit, the **external prosthesis** benefit, counselling arranged through Stronger Minds, consultations through the Saga GP Service, any benefit under the optional Health Cash Benefits Cover or the optional Extended Cancer Cover, including the hospital expenses cash benefit, purchase of wigs or other temporary head coverings, or hospice donation.

Your No Claim Discount (NCD) will not be affected by **eligible treatment** with a **therapist**, **acupuncturist** or **physiotherapist**, the NHS cash benefit, the **external prosthesis** benefit, counselling arranged through Stronger Minds, consultations through the Saga GP Service, any benefit under the optional Health Cash Benefits Cover or the optional Extended Cancer Cover, including the hospital expenses cash benefit, purchase of wigs or other temporary head coverings, or hospice donation.

4 ARRANGING TREATMENT AND MAKING A CLAIM

If you have chosen the Saga Countrywide Hospital List or our London Upgrade, or you live in the Channel Islands or Isle of Man, the following information and that on page 12 applies:

(If you have chosen Fixed Fast Track, please see pages 10-12.)
Please remember that you should obtain authorisation for your claim from us before you start any **treatment** (see opposite for the steps to take). If we ask you to complete a claim form, you must send it to us for confirmation of your cover. If you do not, we may be unable to pay for the **treatment** you receive in full or in part. All **in-patient treatment** and **day-patient treatment** must also take place at a **hospital** listed in the **Saga Countrywide Hospital List**

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

Fast Track Appointments Service

We have a team who can help you find a **fee-approved specialist**. This service is available if your **GP** has given you an **open referral**, meaning they do not specify the **specialist's** name. To get your claim underway, simply call the Claims Personal Advisory Team and tell them you have an **open referral**.

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

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

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

1. *There is no cover for urgent or emergency **treatment**.*
2. *If a **surgical procedure** or **in-patient** or **day-patient treatment** is necessary we will need to establish that **treatment** is not available on the NHS within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed (unless the **surgical procedure** is one specified in the list in section 3 'Benefits table' or you are receiving radiotherapy or chemotherapy as **day-patient treatment** or **out-patient treatment**).*

Working Body

When you experience muscle, bone or joint pain, it is important that you get the most appropriate support early. With 'Working Body' you can get access to advice and **treatment** without the need for a **GP** referral. As soon as you develop a problem, just call the Claims Personal Advisory Team, who will check your cover. Working Body will then call you back by the end of the next working day to arrange a free telephone assessment. If you use Working Body for advice or self-administered exercises (if this is clinically appropriate), this will not affect your existing benefits, as it works alongside these benefits. However, if a Working Body **physiotherapist** recommends **treatment**, then we may need to make some checks before any **treatment** can be authorised and claims are paid, subject to the terms of your **policy**.

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

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

Step One	Your **GP** refers you to a **specialist** for private **treatment**. (For muscle, bone or joint pain, see the 'Working Body' explanation on this page; for skin, breast or prostate concerns, see the 'Self-referral service' explanation on page 9; or for mental health conditions, see the 'Stronger Minds' explanation on page 9.)
Step Two	You need to call us on **0800 027 1331** or go through your online account to check that **treatment** is **eligible**, but please remember that cover for your claim can only be confirmed once we have received the completed claim form. Please help us by having the following details available: • **Specialist/Specialist** type or group practice name • **Hospital** name and any admission dates • A procedure code if you are having a **surgical procedure** • Details of your **medical condition** particularly if your **policy** excludes cover for **treatment** of pre-existing conditions.
Step Three	We will then: • Check that we will pay the **specialist's** fees in full or find a **specialist** for you • Confirm which **hospitals** are covered • Send you a partially completed claim form.
Step Four	Complete your section of the claim form, answering all the questions. Ensure you include the date you first became aware of the condition you are claiming for, and if you have experienced similar symptoms before, tell us when. Ask your **GP** to complete the remainder of the claim form and return it to us at the address shown on the form.
Step Five	Once we have received your completed claim form we will then: • Assess the claim and confirm whether we will cover the **treatment** • Remind you of any benefit restrictions that may affect your claim. (Note: in most of the cases – and provided that your claim form has been completed correctly – we should be able to give you an answer within two working days.)
Step Six	Send in any outstanding accounts for **treatment** to our Claims Personal Advisory Team.

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

Self-referral service

There are some conditions that we offer a self-referral service for. This means you do not need a **GP** referral. If you are concerned about:

- any marks or moles on your skin
- symptoms or changes in your breast(s)
- raised prostate specific antigen test (PSA)

call the Claims Personal Advisory Team who will check your cover and ask you some questions to establish whether the service can help. If they believe it can and you consent to go ahead, the adviser will transfer you to the service, which will then be responsible for making a diagnosis.

If the service is not suitable, or if you prefer not to use it, you should make an appointment with your **GP** as soon as possible for further advice.

Please note:
Family members under the age of 18 will need a **GP** referral.

Stronger Minds

With 'Stronger Minds' you can get prompt access to mental healthcare and support.

If you experience stress, anxiety or any mental health concerns, call the Claims Personal Advisory Team. We may need to make some checks before we can transfer you through to our Stronger Minds team. Once cover is agreed they will arrange for you to speak to a trained counsellor.

The counsellor or, if necessary, a psychologist will carry out an initial clinical needs assessment then recommend a **treatment** plan which is clinically appropriate for you. This could be telephone or face-to-face counselling, a psychiatrist or psychologist consultation or simply some self-help advice.

We will pay for counselling arranged by the Stronger Minds team if this is recommended, and this will not affect your existing benefits. However, if Stronger Minds recommends **treatment** such as with a **specialist** or **practitioner** this will be subject to the terms of your **policy**. These payments will be made direct to the provider.

Please note:
This service is available to over 18s only.

What happens if I require emergency treatment?

*Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: These **policies** will only provide benefit for **in-patient treatment**, **day-patient treatment** and **out-patient surgical procedures** if the NHS cannot provide that **treatment** within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed.*

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

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

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

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

(If you have chosen the Saga Countrywide Hospital List or our London Upgrade, or you live in the Channel Islands or Isle of Man, please see pages 8-9 and 12.)

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

Please remember that you should obtain authorisation for your claim from us before you start any **treatment** (see opposite for the steps to take). If we ask you to complete a claim form, you must send it to us for confirmation of your cover. If you do not, we may be unable to pay for the **treatment** you receive in full or in part.

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

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

GP open referral

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

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

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

Arranging your appointments

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

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

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

1. *There is no cover for urgent or emergency **treatment**.*
2. *If a **surgical procedure** or **in-patient** or **day-patient treatment** is necessary we will need to establish that **treatment** is not available on the NHS within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed (unless the **surgical procedure** is one specified in the list in Section 3 'Benefits table' or you are receiving radiotherapy or chemotherapy as **day-patient treatment** or **out-patient treatment**).*

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

Step One	Your **GP** provides an **open referral** for private **treatment**. (For muscle, bone or joint pain, see the 'Working Body' explanation on page 11; for skin, breast or prostate concerns, see the 'Self-referral service' explanation on page 11; or for mental health conditions, see the 'Stronger Minds' explanation on page 11.)
Step Two	You need to call us on **0800 027 1331** or go through your online account to check that **treatment** is **eligible**, but please remember that cover for your claim can only be confirmed once we have received the completed claim form. Please help us by having the following details available: • **Specialist** type • A procedure code if you need a **surgical procedure** • Details of your **medical condition** particularly if your **policy** excludes cover for **treatment** of pre-existing conditions.
Step Three	We will then: • Check that the **treatment** is **eligible** based on the information provided over the phone • Send you a claim form (if required) • Find up to three **selected providers**, who you are allowed to receive **eligible treatment** from, for you to choose between • Provide you with details of the chosen **selected provider**. If you need to see a **specialist**, we can book the appointment for you. In order to book your appointment with the **specialist** we will need to share some personal information with them, including medical information. In some circumstances, it may be necessary or you may prefer to make the appointment with the **specialist** yourself.
Step Four	Complete your section of the claim form, answering all the questions. Ensure you include the date you first became aware of the condition you are claiming for, and if you have experienced similar symptoms before, tell us when. Ask your **GP** to complete the remainder of the claim form and return it to us at the address shown on the form.
Step Five	Once we have received your completed claim form we will then: • Assess the claim and confirm whether we will cover the **treatment** • Remind you of any benefit restrictions that may affect your claim. (Note: in most of the cases – and provided that your claim form has been completed correctly – we should be able to give you an answer within two working days.)
Step Six	Send in any outstanding accounts for **treatment** to our Claims Personal Advisory Team.

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

Working Body

When you experience muscle, bone or joint pain, it is important that you get the most appropriate support early. With 'Working Body' you can get access to advice and **treatment** without the need for a **GP** referral. As soon as you develop a problem, just call the Claims Personal Advisory Team, who will check your cover. Working Body will then call you back by the end of the next working day to arrange a free telephone assessment. If you use Working Body for advice or self-administered exercises (if this is clinically appropriate), this will not affect your existing benefits, as it works alongside these benefits. However, if a Working Body **physiotherapist** recommends **treatment**, then we may need to make some checks before any **treatment** can be authorised and claims are paid, subject to the terms of your **policy**.

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

Self-referral service

There are some conditions that we offer a self-referral service for. This means you do not need a **GP** referral. If you are concerned about:

- any marks or moles on your skin
- symptoms or changes in your breast(s)
- raised prostate specific antigen test (PSA)

call the Claims Personal Advisory Team who will check your cover and ask you some questions to establish whether the service can help. If they believe it can and you consent to go ahead, the adviser will transfer you to the service, which will then be responsible for making a diagnosis.

If the service is not suitable, or if you prefer not to use it, you should make an appointment with your **GP** as soon as possible for further advice.

Please note:
Family members under the age of 18 will need a **GP** referral.

Stronger Minds

With 'Stronger Minds' you can get prompt access to mental healthcare and support.

If you experience stress, anxiety or any mental health concerns, call the Claims Personal Advisory Team. We may need to make some checks before we can transfer you through to our Stronger Minds team. Once cover is agreed they will arrange for you to speak to a trained counsellor.

The counsellor or, if necessary, a psychologist will carry out an initial clinical needs assessment then recommend a **treatment** plan which is clinically appropriate for you. This could be telephone or face-to-face counselling, a psychiatrist or psychologist consultation or simply some self-help advice.

We will pay for counselling arranged by the Stronger Minds team if this is recommended, and this will not affect your existing benefits. However, if Stronger Minds recommends **treatment** such as with a **specialist** or **practitioner** this will be subject to the terms of your **policy**. These payments will be made direct to the provider.

Please note:
This service is available to over 18s only.

What happens if I require emergency treatment?

*Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: These **policies** will only provide benefit for **in-patient treatment**, **day-patient treatment** and **out-patient surgical procedures** if the NHS cannot provide that **treatment** within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed.*

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

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

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

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

How are my medical bills settled?

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

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

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

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

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

You should send us any receipts for **treatment** within 6 months after you've had your **treatment**, unless this is not reasonably possible.

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

What must I provide when making a claim?

4.1 Before we can consider a claim you must ensure that:

- you obtain and complete any form required by us in order to provide us with the necessary information and necessary legal permissions to handle your medical information and to assess your claim. You will need to do this before starting any **treatment** in order to obtain authorisation for your claim from us; and
- we receive original invoices for **treatment** costs either from you or directly from whoever has provided your **treatment**; and
- you give us all the information we request.

Do I need to provide any other information?

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

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

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

What should I do if another party is responsible for some of my claims costs?

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

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

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

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

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

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

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

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

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

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

5 EXISTING MEDICAL CONDITIONS

Please note:
The following defined terms apply to this section:

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

Pre-existing condition – any disease, illness or injury for which:
- you have received medication, advice or **treatment**; or
- you have experienced symptoms;

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

Please note: when you joined, you may have been able to choose to include cover for **eligible treatment** of pre-existing hypertension and **specified conditions**. If this applies to you it will be shown on your Policy Schedule.

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

Trouble free – when you:
- have not had any medical opinion from a medical practitioner including **GPs** or **specialists**; or
- have not taken any medication (including over the counter drugs) or followed a special diet; or
- have not had any medical **treatment**; or
- have not visited a **practitioner**, **therapist**, **physiotherapist**, **acupuncturist**, optician or dentist;

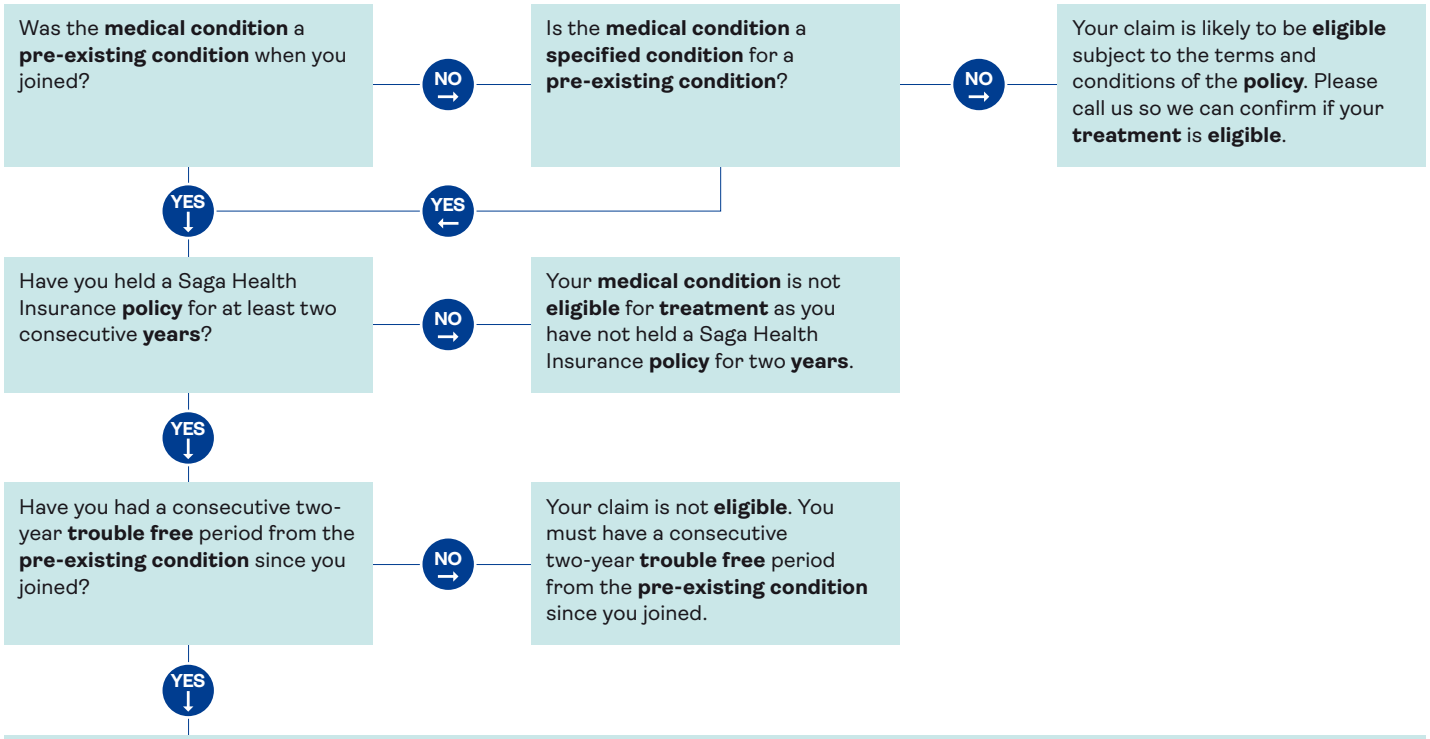
for the **medical condition**.

What cover is there for treatment of any medical conditions that I had prior to joining?

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

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

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



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

Please note: We will exclude **specified conditions** from your cover for at least two **years** after you join if:
- you had diabetes when you joined, or
- you were already aware that you had raised blood pressure (hypertension) when you joined, or
- you were already being investigated, monitored or treated as a result of a PSA (Prostate Specific Antigen) test to do with the prostate, when you joined.

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

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

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

*When you joined, you may have been able to choose to include cover for **eligible treatment** of pre-existing hypertension and **specified conditions** to it. If these apply to you they will be shown on your Policy Schedule.

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

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

What happens when I want to make a claim?

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

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

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

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

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

5.2 What we do not pay for:

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

(b) If you completed a medical history declaration when you joined: we will not pay for **treatment** of any **medical condition** which you already had when you joined and about which you should have told us, but did not tell us at all or did not tell us everything. This includes any such **medical condition(s)** or symptoms, whether or not being treated, and any previous **medical condition(s)** which recurs or which you should reasonably have known about even if you had not consulted a doctor.

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

6 YOUR COVER FOR CERTAIN TYPES OF TREATMENT

What is eligible treatment?

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

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

Will my policy cover me for preventive treatment?

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

Please note:
We do not pay for genetic tests, when those tests are undertaken to establish whether you have a **medical condition** when you have no symptoms or a genetic risk of developing or passing on a **medical condition**. We will pay for genetic testing when it is proven to help choose the best **eligible treatment** for your **medical condition**. Please call us before you have any genetic tests to confirm that we will cover them. Your **specialist** might want to do a variety of tests and they might not all be covered. The cost to you might be significant if the tests are not covered by your **policy**.

What other treatments are not covered?

There are a number of other **treatments** (listed below) that your **policy** does not cover. These include **treatments** that may be considered a matter of personal choice (such as cosmetic **treatment**) and other **treatments** that are excluded from cover to keep premiums at an affordable level (such as **out-patient** drugs and dressings).

6.1 We pay for **eligible**:

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

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

(c) Oral **surgical procedures** listed in the Schedule of Procedures and Fees. If you would like a copy of the Schedule of Procedures and Fees, please contact our Claims Personal Advisory Team.

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

(e) First reconstructive surgery to restore function or appearance after an accident or following surgery for a **medical condition** that was covered by your Saga Health Insurance, provided that:
- we have covered you continuously under a Saga HealthPlan **policy** since before the accident or surgery happened; and
- we agree the cost of the **treatment** before it is done (see also 6.2(t)).

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

(g) Stem cell or bone marrow transplant when that **treatment** is for the **treatment** of **cancer** and is **conventional treatment** for that **cancer**, or a **surgical procedure** using donated stored tissue, where it is integral to the **surgical procedure**, for example ligament reconstruction, replacement heart valve or corneal transplant (see also 6.2(gg)).

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

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

(i) Genetic testing when it is proven to help choose the best **eligible treatment** for your **medical condition**.

Please see the rest of this section for details of **eligible treatment**, **conventional treatment** and **unproven treatment**.

(j) Advance therapy medicinal products (ATMPs) such as gene therapies and CAR-T **treatment** for **cancer**, which are on the list at the time you need the **treatment**. The current list can be found at axahealth.co.uk/atmps or by calling the Claims Personal Advisory Team.

(k) **Treatment** if you need to be referred to a **specialist** by your **GP** for the **treatment** of menopausal symptoms. **We** recommend referral to a **specialist** accredited by the British Menopause Society (BMS). Please ask your **GP** for an open referral so we can support you in finding a BMS specialist, either nearby or one who commonly offers online appointments.

6.2 What we do not pay for:

(a) **Diagnostic tests** other than detailed in 6.1(a) and 6.1(b).

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

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

(d) **Treatment** of symptoms generally associated with the natural process of ageing. This includes **treatment** for the symptoms of puberty or the routine management of menopause.

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

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

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

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

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

6.2 What we do not pay for: (Cont.)

(j) Vaccinations, routine preventive examinations and check-ups or preventive screening or tests.

(k) Preventive **treatment**, such as preventative mastectomy or YAG laser iridotomy for narrow angles in isolation.

(l) Genetic tests:
- to check whether you have a **medical condition** when you have no symptoms; or
- you have a genetic risk of developing a **medical condition** in the future; or
- to find out if there is a genetic risk of you passing on a **medical condition**; or
- where the result of the test wouldn't change the course of **eligible treatment**. This might be because, the course of **eligible treatment** for your symptoms would be the same regardless of the result of the test or what **medical condition** has caused your symptoms; or
- when the tests themselves are not **conventional treatment** or where they are used to direct **treatment** that is not **eligible treatment**.

(m) Genetic tests must be:
- listed in the NHS England National genomic test directory and used for the purposes listed in the directory; and
- carried out at a testing laboratory which is accredited by the United Kingdom Accreditation Service (UKAS) or an equivalent agreed in advance of testing by AXA PPP healthcare.

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

(o) Advanced therapy medicinal products (ATMPs) that are not on our list at the time you need the **treatment**. (See also 6.1(j)).

(p) Any **treatment** costs to plan or facilitate **treatment**, medical or surgical intervention or body modification that is not **eligible** under your **policy** or any further **treatment** or increased **treatment** costs as a result of **treatment**, medical or surgical intervention or body modification that is not covered under the **policy**.

(q) The costs of the purchase, hire or fitting of any external appliance, such as crutches, joints supports, braces, mechanical walking aids or other mobility aids, any external device such as **treatment** or monitoring devices, or any **external prosthesis**, except as allowed in benefits 16 and 25(ii).

(r) The costs of any replacement teeth or hair, including wigs (except as allowed under 25(i)) or hair transplants.

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

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

(u) Any **treatment** that is connected with the use of cosmetic (beauty) products or is needed as a result of using a cosmetic (beauty) product.

(v) The removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons (including but not limited to breast reduction).

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

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

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

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

(aa) Any charges which you incur for social or domestic reasons (such as travel or home help costs) or for reasons which are not directly connected with **treatment**.

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

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

(dd) Any **treatment** needed as a result of nuclear contamination, biological contamination or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed.

Please note, for clarity: There is cover for **treatment** required as a result of a **terrorist act** providing that the **terrorist act** does not result in nuclear, biological, or chemical contamination.

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

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

(gg) Any surgery or **treatment** required to receive an organ, donate an organ, **treatment** needed in preparation or as a result of a transplant, the cost of collecting donor organs, tissue or harvesting cells from a donor, or any related administration costs.

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

*Anything outside the terms of cover, which for clarity includes any urgent or emergency **treatment**. We also do not pay for **treatment** of any **medical condition** unless recommended **treatment** is not available under the NHS within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed. This requirement does not apply to those **surgical procedures** listed in section 3 'Benefits table' or radiotherapy or chemotherapy as **day-patient** or **out-patient treatment**.*

Will my policy cover me for new or unproven treatments?

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

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

and has either:
- been approved by NICE (the National Institute for Health and Care Excellence) as a **treatment** which may be used in routine practice; or
- been proven to be effective and safe for the **treatment** of your **medical condition** through high-quality clinical trial evidence (full criteria available on request).

Are there any additional requirements for drug treatments?

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

Are there any additional requirements for surgical treatments?

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

Are there any additional requirements for medical devices?

If the **treatment** involves a **medical device** (including surgical devices and implants), it must:
- be approved by current EU Medical Device Regulations; and
- have moderate or high-quality evidence of safety and effectiveness from either:
  - systemic reviews of randomised controlled trials; or
  - clinical trial evidence with three years of follow-up data.

Will the policy cover me for unproven treatment?

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

We define **unproven treatment** as:
- surgery not listed and identified in the Schedule of Procedures and Fees; and
- other **treatments** and **diagnostic tests** which are not **conventional treatments**.

If your **specialist** wants to carry out **treatment** that is not **conventional treatment**, it must be authorised by us before it takes place and it must take place in the **UK**. We will need to agree that the **unproven treatment** is a suitable equivalent to **conventional treatment** and the **treatment** must have high-quality evidence of its safety.

Are there restrictions on what you pay for unproven treatment?

If you receive **treatment** as part of a registered clinical trial we will not cover the costs of the **treatment**, or the **specialist**, **hospital** or any other costs associated to the trial.

By registered clinical trial we mean a prospectively registered trial in humans registered on the World Health Organisation's International Clinical Trials Platform (https://www.who.int/ictrp/en/) that includes a treatment group (the new treatment) and a control group (either usual care or a placebo).

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

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

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

Yes, if you would like an **unproven treatment** you or your **specialist** must contact us at least 10 working days before you book that **treatment**. This is so we can:
- obtain full details of the **unproven treatment** and the supporting clinical evidence;
- support you with additional information and questions for your **specialist**, before you have **treatment**;
- agree what costs (if any) we will pay towards the **hospital**, **specialist**, anaesthetist and/or other provider. All **unproven treatment** must be agreed by us in writing, so you are clear how much we will pay towards your **treatment**.

If you do not contact us at least 10 days before you book your **treatment**, there will be no cover for **unproven treatment**. You cannot pay for **unproven treatment** yourself and reclaim the costs from us.

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

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

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

Childbirth, pregnancy and sexual health

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

Be aware:
As the extent of cover is limited in pregnancy and childbirth it is important to call our Claims Personal Advisory Team so we can confirm the extent of the cover we will provide before you undertake any **treatment**.

6.3 We pay for **eligible**:

(a) Additional costs incurred for the **treatment** of **medical conditions** when they occur during pregnancy or childbirth. As an illustration we would consider **treatment** of the following:
- ectopic pregnancy (where the foetus is growing outside the womb)
- hydatidiform mole (abnormal cell growth in the womb)
- retained placenta (afterbirth retained in the womb)
- eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
- post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
- miscarriage requiring immediate surgical **treatment**.

6.4 What we do not pay for:

(a) Any costs related to pregnancy or childbirth except the additional costs incurred for **eligible treatment** of a **medical condition**.

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

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

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

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

(f) Gender re-assignment operations or any other surgical or medical **treatment** directly or indirectly associated with, gender re-assignment.

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

7 RECURRENT, CONTINUING AND LONG-TERM TREATMENT

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

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

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

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

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

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

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

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

In the unfortunate event that the **treatment** you are receiving becomes recurrent, continuing or long-term, so you need consultations over a long period, checks on your medication, long-term therapy or **treatment** to ease symptoms, your condition may fall within the definition of a **chronic condition**.

What does it mean if my condition is chronic?

If we think that your condition is now a **chronic condition**, we may contact your **specialist** or **GP** (we will ask you first). We will ask them to confirm your diagnosis and tell us what **treatment** you are receiving. We will also ask them how they think your condition will progress. If this information confirms that you have a **chronic condition**, we will write to you to confirm that we will no longer cover your **treatment** privately. You will then need to return to the NHS or fund private treatment yourself. You will have time to talk to your **GP** or **specialist** about your options.

What if my condition gets worse?

We will pay for short-term **in-patient treatment** of acute exacerbations or complications (flare-ups) in order to bring the condition back to its controlled state. However, there are certain conditions that are likely to require ongoing **treatment** or recur – such as Crohn's disease (inflammatory bowel disease) – which require management of recurrent episodes where the condition's symptoms deteriorate. Because of the ongoing nature of these conditions we will write to tell you when the benefit for that condition will stop. Exclusions that would normally apply to long-term or **chronic conditions** may not apply to **cancer**. You will find a further explanation of how we deal with payment for **cancer treatments** later in this section.

7.1 We pay for **eligible**:

(a) **Treatment** of an **acute condition** and the short-term **in-patient treatment** intended to stabilise and bring under control a **chronic condition**.

(b) **In-patient** rehabilitation of up to 28 days when it is part of **treatment** of an **acute condition** that is covered by your **policy**; and:

- it follows an acute brain injury, such as a stroke; and
- it is carried out by a **specialist** in rehabilitation; and
- it is carried out in a recognised rehabilitation **hospital** or unit which is either listed in the **Saga Countrywide Hospital List** or which we have written to confirming it is recognised by us; and
- it could not be carried out on a **day-patient** or **out-patient** basis or in another appropriate setting; and
- the costs have been agreed by us before the rehabilitation begins.

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

7.2 What we do not pay for:

(a) Ongoing, recurrent or long-term **treatment** of any **chronic condition**.

(b) The monitoring of a **medical condition**.

(c) Any **treatment** which only offers temporary relief of symptoms rather than dealing with the underlying **medical condition**.

(d) Routine follow-up consultations.

(e) Regular or long-term dialysis in the case of chronic organ failure.

(f) Any hormone replacement therapy (HRT).

What cover do I have for mental health treatment?

You have cover for mental health conditions with up to 28 days' **in-patient** or **day-patient treatment**, £1,500 of **out-patient treatment** and counselling arranged by the Stronger Minds team, subject to all other benefit limitations, exclusions and underwriting on your **policy**.

Should you require **in-patient treatment** of a mental health condition, the **hospital** will contact us prior to your admission to check whether your **policy** will cover that **treatment**. If we are able to confirm cover we will agree with the **hospital** to pay for an initial period of hospitalisation.

*Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: There is no cover for urgent or emergency **treatment** or for **in-patient** or **day-patient treatment** that is available on the NHS within four/six weeks after the date on which the **treatment** should be undertaken. Therefore, it is unlikely that there will be cover under these **policies** for such mental health* **treatment**.

Should you need to stay in **hospital** longer than was initially agreed then we will ask the **specialist** to provide further details to enable us to assess why further **treatment** is necessary. Any cover for **treatment** of mental health conditions will be subject to our rules on **chronic conditions** above.

7.3	We pay for **eligible**:
(a)	**In-patient** or **day-patient treatment** of a mental health condition, up to the limits shown in the **benefits table**. We have an agreement with psychiatric **hospitals** regarding **in-patient treatment** of mental health conditions under which the **hospital** will contact us directly to confirm whether cover is available.
(b)	**Out-patient treatment** of a mental health condition, subject to any **out-patient treatment** limits as shown in the **benefits table**.
(c)	Counselling provided through the Stronger Minds service (for over 18s).

Your cover for cancer treatment

You are covered for **treatment** of a new **cancer** which arises after you join and for any recurrence of this **cancer**. If you have exclusions because of your past medical history which relate to a **cancer**, then you will not be covered for any recurrence of that **cancer**. Please refer to section 5 'Existing medical conditions' for further information on your cover for pre-existing **medical conditions**.

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

If you do not have Extended Cancer Cover: The **policy** does not cover the long-term management of **cancer** other than shown on the table opposite and there is no cover for **treatment** given solely to relieve symptoms.

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

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

*If you have Saga HealthPlan Saver Plus 4 or Saga HealthPlan Saver Plus 6 please note that this cover is subject to the restrictions on this **policy** on:*

- *any urgent or emergency **treatment***
- ***treatment** that is available under the NHS within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed.*

Please note:
If you have Extended Cancer Cover (this will be shown on your Policy Schedule) the table shown in this section on pages 21-22 is replaced. Please refer to pages 23-24 for the new table showing details of your extended cover for **cancer**.

NHS or private?

Whilst you are covered for **eligible active treatment of cancer** on this **policy**, there are alternative methods of using your **policy** following a diagnosis of **cancer**. If you should decide that you want to receive **treatment** on the NHS instead of using your **policy** to have private **treatment**, there are options available to you which provide financial assistance.

If you are diagnosed with **cancer** – please call us on 0800 027 1331 so we can explain how we can support you.

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

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

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

Summary of cover for cancer

	Cover	
Where am I covered for treatment?	✓	**Active treatment of cancer** at any **hospital** listed in the **Saga Countrywide Hospital List** or, if you have chosen Fixed Fast Track, a **hospital** we have chosen with you.
	✗	Charges made for the **treatment** of **cancer** at any hospital not listed in the **Saga Countrywide Hospital List** or, if you have chosen Fixed Fast Track, a hospital we have not chosen with you.
	✓	Home nursing received at home in the circumstances shown in the **benefits table**.
	✓	Chemotherapy by intravenous drip at home. Please refer to 'Your cover for cancer treatment' on page 20 for more information.
	✓	**Treatment** received at a hospice.
What cover do I have for diagnostic tests/ procedures?	✓	Consultations with a **specialist** treating your **cancer**, **diagnostic tests** ordered by a **GP** or ordered or performed by a **specialist** treating your **cancer**, CT, MRI and PET scans ordered by a **specialist** treating your **cancer** and **surgical procedures**. If any of these take place before a diagnosis of **cancer**, the costs will be subject to any **out-patient** benefit limits.
	✓	Cover for genetic testing proven to help the selection of appropriate chemotherapy.
	✗	Genetic screening required to establish a genetic pre-disposition to certain forms of **cancer**. For more information on genetic testing, please see section 6.
What cover do I have for surgical treatment?	✓	**Surgical procedures** for the **treatment** or diagnosis of **cancer**, as shown in section 6 'Your cover for certain types of **treatment**', when that **treatment** is **conventional treatment**. For more information on **conventional treatment** and **unproven treatment**, please see section 6.
	Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6	*At the time of going to print the NHS was commonly providing surgical **treatment** of **cancer** within 31 days and therefore it is unlikely that there will be cover on these **policies** for such surgical **treatment**.*
What cover do I have for reconstructive surgery following breast cancer?	✓	The first reconstructive surgery following a **surgical procedure** for breast **cancer**. We will cover: • one planned **surgical procedure** to reconstruct the diseased breast • one planned **surgical procedure** to reconstruct the nipple • up to two sessions of nipple tattooing. We will do this as long as: • we have covered you continuously under a Saga HealthPlan **policy** since before surgery happened; and • we agree the method and cost of the **treatment** in writing beforehand.
	✓	After the completion of your first reconstructive surgery, we will also cover: • one further planned **surgical procedure** to the other breast, when it has not been operated on, to improve symmetry. • two planned fat transfer surgeries. The fat must be taken from another part of your body and cannot be donated by someone else. • one planned **surgical procedure** to remove and exchange implants damaged by radiotherapy **treatment** for breast **cancer**. Symmetry and fat transfer operations must take place within three years of you completing your first reconstructive **surgical procedure**. The removal and exchange of radiotherapy damaged implants must take place within five years of you completing your radiotherapy **treatment**. We will only pay for each of these operations once (or two fat transfer surgeries), regardless of how long you remain a Saga Health Insurance **policyholder**.
	✓	If you choose not to have reconstructive surgery following **treatment** of breast **cancer**, we will cover the cost of one planned **surgical procedure** to the unaffected breast to improve symmetry. There is no cover for any further reconstructive surgery on either the diseased or the unaffected breast.
	✗	Any **treatment** relating to previous cosmetic or reconstructive **treatment**, including any cosmetic operations to a reconstructed breast.
Am I covered for preventive treatment?	✗	Preventive **treatment**, for example: • Screening undertaken as a preventive measure where there are no symptoms of **cancer**. For example, if you receive genetic screening to see if you have a genetic predisposition to breast **cancer**, you would not be covered for the screening or a prophylactic mastectomy to prevent the development of breast **cancer** in the future. • Vaccines to prevent the development or recurrence of **cancer**, for example vaccinations for the prevention of cervical **cancer**.

	Cover	
What cover do I have for drug therapy?	✓	Drug **treatment** of **cancer** (such as chemotherapy drugs, hormone therapies and biological therapies) where the drug has been licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and is used within the terms of that licence.
	✓	There are some drug **treatments** for **cancer** that are typically given for prolonged periods of time. Such prolonged **treatment** normally falls outside benefit. However in the case of **treatment** of **cancer** we make an exception (subject to the limits detailed below) for chemotherapy drugs and biological therapies such as trastuzumab (Herceptin) and bevacizumab (Avastin). **Please note:** Changes in drug licensing mean that **cancer** drug **treatment** covered under this **policy** will change from time to time. For further information on licensed **cancer treatment** please contact our Claims Personal Advisory Team once you know your **treatment** plan. These drug **treatments** will be covered for up to: • 18 months of such **treatment**; or • the period of the drug licence whichever is the shorter. The time limit starts from when you first started receiving the drug **treatment** funded by us and does not get reset if the type of drug you are receiving changes during the course of **cancer treatment**. In any event, these drugs will only be **eligible** for benefit when they are used within the terms of their licence and in circumstances where they are proven to be effective **treatments**. Within these time limits there is also cover for antivirals, antibiotics, antifungals, anti-sickness and anticoagulant drugs while you are undergoing **eligible** chemotherapy for **cancer**.
	✓	There is cover for a small number of approved advanced therapy medicinal products (ATMPs). Please see axahealth.co.uk/atmps for the list of ATMPs covered, or call the Claims Personal Advisory Team. (See also 6.1(j)).
	✗	Except for the cover provided for chemotherapy drugs and biological therapies previously described, there is no cover for drug **treatment** given to prevent a recurrence of **cancer**, for the maintenance of remission or where its use is continuing without a clear end date. Such ongoing **treatments** are not **eligible** although, if they are given by injection, for example goserelin (Zoladex), we would pay for up to three months to allow the **treatment** to be established.
	✗	**Out-patient** drugs and drugs prescribed by your **GP** or that could be bought over the counter are not covered by your **policy**. This includes any take-home drugs or prescriptions you are given following **in-patient**, **day-patient** or **out-patient treatment**. For example, hormone therapy tablets (such as Tamoxifen) are **out-patient** drugs and therefore are not covered by our policies.
Am I covered for radiotherapy?	✓	Radiotherapy, including when used to relieve pain.
Am I covered for proton beam therapy (PBT)?	✓	We will pay for PBT for **cancer** when it is in line with **treatment** that is routinely commissioned by the NHS. There is no cover for PBT in any other circumstances. As PBT is a developing area of medicine there are only a limited number of facilities that provide this **treatment**. Please contact us before you have your **treatment**.
Am I covered for accelerated charged particle therapies?	✗	There is no cover for accelerated charged particle therapies. However, there is limited cover for proton beam therapy in the circumstances shown above.
Am I covered for terminal care?	✗	There is no cover for terminal care, wherever carried out.
Am I covered for monitoring?	✓	Follow-up consultations and reviews of **cancer** will be covered as long as you remain a Saga HealthPlan **policyholder**, subject to the terms and conditions of that policy at the time. **Please note:** We will not pay for routine checks that could typically be carried out by your **GP**. These will not affect your **out-patient** benefit limits. *Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: Some **cancer** patients may need follow-up procedures such as colonoscopies or cystoscopies, which are needed not in order to provide **treatment** but to monitor the patient as part of the planned management. These procedures can be scheduled in advance on the NHS for whenever they are needed and are not covered by these **policies**, as they would be available under the NHS within four/six weeks from the date on which they should take place.*
Am I covered for bone marrow or stem cell treatment?	✓	We will cover the reasonable costs for a stem cell or bone marrow transplant, as long as: • the stem cell or bone marrow transplant is for the **treatment** of **cancer**; and • it is **conventional treatment** for that **cancer**. Please see section 6 'Your cover for certain types of treatment' for more information on **conventional treatment**.
	✗	There is no cover for any related administration costs. For example, we will not cover the cost of searching for a donor, the harvesting of cells from the donor or transport costs for the tissue or harvested cells.

EXTENDED CANCER COVER

Additional cover for cancer treatment

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

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

The hospital expenses cash benefit is paid out in full once a diagnosis of **cancer** has been made and, for example, can be used towards hospital car parking. Please see the **benefits table** on page 7 for more information.

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

	Cover	
Where am I covered for treatment?	✓	**Active treatment of cancer** at any **hospital** listed in the **Saga Countrywide Hospital List** or, if you have chosen Fixed Fast Track, a **hospital** we have chosen with you.
	✗	Charges made for the **treatment** of **cancer** at any hospital not listed in the **Saga Countrywide Hospital List** or, if you have chosen Fixed Fast Track, a hospital we have not chosen with you.
	✓	Home nursing received at home in the circumstances shown in the **benefits table**.
	✓	Chemotherapy by intravenous drip at home. Please refer to 'Your cover for cancer treatment' on page 20 for more information.
What cover do I have for diagnostic tests/ procedures?	✓	Consultations with your **cancer**-treating **specialist** (such as an oncologist, surgeon, radiotherapist or haematologist), **diagnostic tests** ordered by a **GP** or ordered or performed by your **cancer**-treating **specialist**, including CT, MRI and PET scans and **surgical procedures**. If any of these take place before a diagnosis of **cancer**, the costs will be subject to any **out-patient** benefit limits.
	✓	Cover for genetic testing proven to help the selection of appropriate chemotherapy.
	✗	Genetic screening required to establish a genetic pre-disposition to certain forms of **cancer**. For more information on genetic testing, please see section 6.
What cover do I have for surgical treatment?	✓	**Surgical procedures** for the **treatment** or diagnosis of **cancer**, as shown in section 6 'Your cover for certain types of **treatment**', when that **treatment** is **conventional treatment**.
	Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6	At the time of going to print the NHS was commonly providing surgical ***treatment*** of ***cancer*** within 31 days and therefore it is unlikely that there will be cover on these ***policies*** for such surgical ***treatment***.
What cover do I have for reconstructive surgery following breast cancer?	✓	The first reconstructive surgery following a **surgical procedure** for breast **cancer**. We will cover: • one planned **surgical procedure** to reconstruct the diseased breast • one planned **surgical procedure** to reconstruct the nipple • up to two sessions of nipple tattooing. We will do this as long as: • we have covered you continuously under a Saga HealthPlan **policy** since before surgery happened; and • we agree the method and cost of the **treatment** in writing beforehand.
	✓	After the completion of your first reconstructive surgery, we will also cover: • one further planned **surgical procedure** to the other breast, when it has not been operated on, to improve symmetry. • two planned fat transfer surgeries. The fat must be taken from another part of your body and cannot be donated by someone else. • one planned **surgical procedure** to remove and exchange implants damaged by radiotherapy **treatment** for breast **cancer**. Symmetry and fat transfer operations must take place within three years of you completing your first reconstructive **surgical procedure**. The removal and exchange of radiotherapy damaged implants must take place within five years of you completing your radiotherapy **treatment**. We will only pay for each of these operations once (or two fat transfer surgeries), regardless of how long you remain a Saga Health Insurance **policyholder**.
	✓	If you choose not to have reconstructive surgery following **treatment** of breast **cancer**, we will cover the cost of one planned **surgical procedure** to the unaffected breast to improve symmetry. There is no cover for any further reconstructive surgery on either the diseased or the unaffected breast.
	✗	Any **treatment** relating to previous cosmetic or reconstructive **treatment**, including any cosmetic operations to a reconstructed breast.
Am I covered for preventive treatment?	✗	Preventive **treatment**, for example: • Screening undertaken as a preventive measure where there are no symptoms of **cancer**. For example, if you receive genetic screening to see if you have a genetic predisposition to breast **cancer**, you would not be covered for the screening or a prophylactic mastectomy to prevent the development of breast **cancer** in the future. • Vaccines to prevent the development or recurrence of **cancer**, for example vaccinations for the prevention of cervical **cancer**.

	Cover	
What cover do I have for drug therapy?	✓	Drug **treatment** of **cancer** (such as chemotherapy drugs, hormone therapies and biological therapies) where the drug has been licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and is used within the terms of that licence.
	✓	There are some drug **treatments** for **cancer** that are typically given for prolonged periods of time. Such prolonged **treatment** normally falls outside benefit. However, in the case of **treatment** of **cancer** we make an exception (subject to the limits detailed below) for chemotherapy drugs and biological therapies such as trastuzumab (Herceptin) and bevacizumab (Avastin). These drug **treatments** will be **eligible** for benefit when they are used within the terms of their licence and up to the period of the drug licence. **Please note:** changes in drug licensing mean that **cancer** drug **treatments** covered under this **policy** will change from time to time. For further information on licensed **cancer treatment** please contact our Claims Personal Advisory Team once you know your **treatment** plan.
	✓	There is cover for a small number of approved advanced therapy medicinal products (ATMPs). Please see axahealth.co.uk/atmps for the list of ATMPs covered, or call the Claims Personal Advisory Team. (See also 6.1(j)).
	✗	There is no cover for unproven drugs or drugs that are being used outside of their licence. However, if you have been invited to be a participant in a randomised clinical trial which has been approved by the appropriate ethics committee, you will be eligible to claim the NHS cash benefit (as detailed on page 7).
	✓	Cover for chemotherapy and/or biological drug **treatment** given to prevent a recurrence of **cancer**, for the maintenance of remission or where its use is continuing without a clear end date. Cover for bisphosphonates used to prevent bone damage in **cancer** when they are licensed for use by the European Medicines Agency or the Medicines and Healthcare Products Regulatory Agency and used according to that licence. They are also covered when they are being used as recommended by the National Institute for Health and Care Excellence (NICE) as a **treatment** that may be used in routine practice. In addition we will cover the cost of injectable hormone **treatment** used to manage your **cancer** while you are undergoing **eligible** chemotherapy for **cancer**. There are also some drugs given to treat conditions secondary to **cancer**, such as erythropoietin (EPO), which will be covered while you are undergoing **eligible** chemotherapy for **cancer**. There is also cover for antivirals, antibiotics, antifungals, anti-sickness and anticoagulant drugs while you are undergoing **eligible** chemotherapy for **cancer**. **Please note:** changes in drug licensing mean that **cancer** drug **treatments** covered under this **policy** will change from time to time. For further information on licensed **cancer treatment**, please contact our Claims Personal Advisory Team once you know your **treatment** plan.
	✗	Bisphosphonates or bone strengthening drugs that can be prescribed by your **GP**
	✗	**Out-patient** drugs and/or drugs prescribed by your **GP** or that could be bought over the counter are not covered by your **policy**. This includes any take-home drugs or prescriptions you are given following **in-patient**, **day-patient** or **out-patient treatment**. For example, hormone therapy tablets (such as Tamoxifen) that are not administered alongside **eligible** chemotherapy for **cancer** would not be covered by our policies.
Am I covered for radiotherapy?	✓	Radiotherapy, including when used to relieve pain.
Am I covered for proton beam therapy (PBT)?	✓	We will pay for PBT for **cancer** when it is in line with **treatment** that is routinely commissioned by the NHS. There is no cover for PBT in any other circumstances. As PBT is a developing area of medicine there are only a limited number of facilities that provide this **treatment**. Please contact us before you have your **treatment**.
Am I covered for accelerated charged particle therapies?	✗	There is no cover for accelerated charged particle therapies. However, there is limited cover for proton beam therapy in the circumstances shown above.
Am I covered for palliative or end of life care?	✓	**Active treatment of cancer** needed regardless of whether the intention of this **treatment** is to cure.
	✓	Secondary **surgical procedures** needed to relieve symptoms as a direct result of **cancer**, such as the insertion of a stent or draining of fluid.
	✓	We will make a charitable donation to a registered hospice charity that is providing you with end of life care either in a hospice or for hospice at home.
Am I covered for monitoring?	✓	Follow-up consultations and reviews of **cancer** will be covered as long as you remain a Saga HealthPlan **policyholder** with an appropriate cancer benefit. Cover will be subject to the **policy** terms and conditions at that time. **Please note:** We will not pay for routine checks that could typically be carried out by your **GP**. These will not affect your **out-patient** benefit limits. *Saga HealthPlan Saver Plus 4 and Saga HealthPlan Saver Plus 6: Some **cancer** patients may need follow-up procedures such as colonoscopies or cystoscopies, which are needed not in order to provide **treatment** but to monitor the patient as part of the planned management. These procedures can be scheduled in advance on the NHS for whenever they are needed and are not covered by these **policies**, as they would be available under the NHS within four/six weeks from the date on which they should take place.*
Am I covered for bone marrow or stem cell treatment?	✓	We will cover the reasonable costs for a stem cell or bone marrow transplant, as long as: • the stem cell or bone marrow transplant is for the **treatment** of **cancer**; and • it is **conventional treatment** for that **cancer**. Please see section 6 'Your cover for certain types of treatment' for more information on **conventional treatment**.
	✗	There is no cover for any related administration costs. For example, we will not cover the cost of searching for a donor, the harvesting of cells from the donor or transport costs for the tissue or harvested cells.

8 WHO WE PAY FOR TREATMENT AND WHERE YOU CAN BE TREATED

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

(If you have chosen Fixed Fast Track, please see page 27.)

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

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

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

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

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

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

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

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

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

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

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

Be aware:
Very occasionally the arrangement we have with a **specialist** may change, for example a **fee-approved specialist** may move to the fee-limited **specialist** category. This means that what we will pay for **treatment** with that **specialist** may also change. It's important you contact us before you see the **specialist** or have any **treatment** so that we can tell you what you're covered for.

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

What if an anaesthetist becomes involved in my treatment?

Before receiving surgical **treatment** it is advisable to establish which anaesthetist your **specialist** intends to use. This will mean we can tell you if that anaesthetist is a **fee-approved specialist**. However, if you don't know when you call us which anaesthetist your **specialist** intends to use we will make every effort to notify you whether they commonly work with an anaesthetist who we do not pay in full. If you choose to receive **treatment** with an anaesthetist who is a **fee-limited specialist**, we will pay up to the amount shown within the Schedule of Procedures and Fees towards the charges for their services.

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

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

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

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

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

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

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

If you have **eligible in-patient treatment** as an NHS patient incurring no charges at all, then we will pay any NHS cash benefit as shown under benefit 15 in the **benefits table**.

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

Your **policy** includes cover for computerised tomography (CT), magnetic resonance imaging (MRI) scans and positron emission tomography (PET). If you require CT, MRI or PET we will make full payment, subject to the terms of your **policy**, if you use a **scanning centre** listed in the **Saga Countrywide Hospital List**.

We will pay in full for **eligible treatment** charges made by an authorised **out-patient** facility, as long as the **treatment** is covered by your **policy**, a **specialist** is overseeing it and the facility is recognised by us to provide **out-patient** services. Yes as sometimes we may allow a member to use, but it's not in the Countrywide list. The definition of 'facility' is a hospital within the Countrywide list, as such it is correct that facility is not bolded. Please always check with us beforehand to make sure the facility you want to go to is recognised. We do not pay for **out-patient** drugs or dressings.

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

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

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

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

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

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

8.1 We pay for **eligible**:

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

(b) Charges made by, or incurred in, a private **hospital** or any NHS hospital for ITU (Intensive Therapy Unit, sometimes called Intensive Care Unit) **treatment** only when:
- you are already having **eligible** private **treatment**; and
- the ITU **treatment** immediately follows **eligible** private **treatment**; and
- you or your next of kin have asked for the ITU **treatment** to be received privately; and
- we have agreed the costs before you start the intensive care **treatment**. (See also section 4 for emergency **treatment**.)

(c) NHS cash benefit, as shown on the **benefits table**, for each night you receive free **treatment** in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.

8.2 What we do not pay for:

(a) Any drugs or **treatment** when the person who refers you is a member of your family, or if the person who is treating you is a member of your family.

(b) **Treatment** charges made by a **fee-approved specialist** or **therapist** who we have identified to you as someone whose fees we will pay in full if, without our prior agreement, they charge significantly more than their usual amount for **treatment**.

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

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

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

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

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

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

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

(If you have chosen the Saga Countrywide Hospital List or our London Upgrade, or you live in the Channel Islands or Isle of Man, please see pages 25-26.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Charges made by, or incurred in, a private **hospital** or any NHS hospital for ITU (Intensive Therapy Unit, sometimes called Intensive Care Unit) **treatment** only when:
- you are already having **eligible** private **treatment**; and
- the ITU **treatment** immediately follows **eligible** private **treatment**; and
- you or your next of kin have asked for the ITU **treatment** to be received privately; and
- we have agreed the costs before you start the intensive care **treatment**. (See also section 4 for emergency **treatment**.)

(c) NHS cash benefit, as shown on the **benefits table**, for each night you receive free **treatment** in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.

8.4 With Fixed Fast Track we do not pay for:

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

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

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

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

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

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

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

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

9 HEALTH CASH BENEFITS COVER

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

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

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

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

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

Dental care

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

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

9.2 We do not pay the cash benefit for:

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

Optical care

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

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

9.4 We do not pay the cash benefit for:

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

Dental accident

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

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

9.6 We do not pay the cash benefit for:

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

Dental emergency

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

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

9.8 We do not pay the cash benefit for:

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

Health assessment

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

(a) A health assessment, which is a package of medical and non-invasive tests that give you a clear picture of your health and wellbeing.
(b) A health assessment when it takes place at a screening facility in a registered **hospital** or in a mobile screening facility under contract with a registered **hospital** by medically qualified staff.

9.10 We do not pay the cash benefit for:

(a) Health assessments other than as stated in 9.9(a) (including tests completed at a retail outlet or health club).
(b) Tests which have been received in order to further legal/industrial action related to employment or emigration or as part of a pension scheme or insurance claim.
(c) Additional tests or screens which fall outside your chosen health assessment package.

How to make a claim under your Health Cash Benefits Cover

To ensure your Health Cash Benefits Cover claim proceeds smoothly, please follow these simple steps	
Step One	Arrange for a Health Cash Benefits Cover claim form to be completed and send it to us with the original receipted account(s) showing a full description and date of the consultation, **treatment** or service provided, and the name of the person the charges apply to. If you do not have a claim form, you can print one from our website at saga.co.uk/health-insurance, alternatively please request one by calling our Claims Personal Advisory Team on **0800 027 1331** (Monday to Friday 8am-8pm, Saturday 9am-5pm).
Step Two	The claim form should be received by us within 13 weeks of: • the date on the original receipted account for consultation and associated charges; or • the date on the original receipted account for charges made (where such **treatment** continues over an extended period, claims need to be submitted periodically, at intervals not exceeding 13 weeks).
Step Three	Once we have received your completed claim form we will assess the claim and reimburse you by cheque up to the maximum amount payable as stated in the **benefits table**.
Please send correspondence to: Saga Claims Personal Advisory Team, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL.	

10 ADDITIONAL INFORMATION

When can I add other family members or change my cover?

You can apply to add a **family member** to your **policy** at any time. Also, you may be able to change your cover at your renewal. Call Saga on 0800 056 9273 to discuss the options open to you and we will send you any relevant forms to complete. You must keep Saga fully informed of any changes which take place between sending in any form and receiving written confirmation that the change has been made.

Can I add my new baby to my policy?

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

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

Can I cancel my policy?

You have a 14 day cooling-off period when you join and at each renewal in which to cancel your **policy** and receive a refund of your premium provided no claims have been made. After the 14 day cooling-off period, if no claims have been made, you may cancel your **policy** by providing 14 days' notice and we will refund any premium for unused cover.

If you do make a claim in the **policy year** and cancel before or after the 14 day cooling-off period, we may ask you to pay for the services we have provided in connection with the **policy**. You may be entitled to a refund of your premium for unused cover by paying us back for any claims paid during the **policy year**. Please see 12.1(g) and 12.1(h) in the section 'Complaint and regulatory information'.

How can I pay my premium?

This **policy** lasts for one **year** and at the start of each **policy year** we will calculate your new premium and let you know how much it is. We offer a choice of monthly or annual premiums which can be paid by Direct Debit. In addition, we offer a choice of annual premiums which can be paid by cheque, debit or credit card. We offer a discount if you pay annual premiums and each annual premium payment is for one **year's** cover. If you pay monthly, each premium payment is for one month's cover.

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

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

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

Why do you make changes to my premium?

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

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

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

How does the No Claim Discount scale operate?

This **policy** has a No Claim Discount (NCD) and your current NCD level is shown on your Policy Schedule, this means that in any NCD year:

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

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

What is a claim?

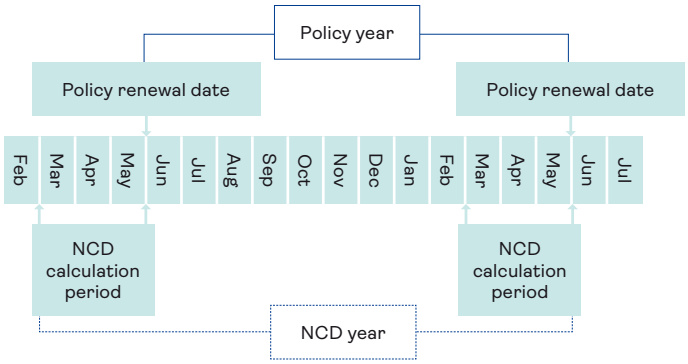
- We will consider any **treatment** for the same **medical condition**, received within 12 months of the date that **treatment** first started, as one single claim;
- For the purposes of the NCD a claim is any amount of money we pay for providing **treatment** for one **medical condition**, no matter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

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

When do you calculate the NCD?

Your NCD level is calculated up to 3 months prior to your **policy** renewal date. This means that a claim paid in the NCD calculation period may not impact on your NCD until the following **year's** renewal. The following diagram shows how the NCD calculation period works for a customer whose **policy** renews in June. Please refer to your Policy Schedule for confirmation of when your **policy** renews.

Illustrative example



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

If you pay for your **treatment** yourself or have it on the NHS, this will not affect your discount level. So if your **treatment** only costs a small amount, when you come to renew your **policy**, you can choose to pay us back for any claims paid during the previous year. If you do this within 30 days of the **policy** renewal date we will recalculate your premium so you continue to benefit from the NCD.

Can I protect my NCD?

We may offer this option on the **policy** for an additional premium, if no claims have been made in the last two years. If so, this will be shown on your Policy Schedule at renewal and you must accept this offer within 30 days of the renewal date.

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

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

How can an excess help to reduce my premium?

Choosing an excess on your **policy** may help to reduce your premiums. If you would like to find out how to add an excess or change your existing excess level please call the Saga Customer Care Team on 0800 056 9273.

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

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

- The excess (that is, the amount of money you have to pay towards the cost of **eligible treatment**) applies to every person covered by the **policy** in each **policy year**.
- We will not pay any claim or part of a claim which is subject to an excess. In this case we will only pay the balance of the claim after we have deducted the excess amount.
- The excess is deducted from any **eligible treatment** costs you incur.
- The excess is a single deduction that is made regardless of the number of individual **medical conditions** claimed for in that **policy year**. Should **treatment** continue beyond your **policy's** renewal date then we will apply the excess once against the costs incurred before this date, and again against the costs incurred on or after the renewal date. We will do this irrespective of whether the costs relate to **treatment** for the same **medical condition**.
- If the first claim relates to a benefit with a monetary limit, then we will reduce the monetary limit by the total cost incurred before we apply the excess. If you have a high excess then you may find that, within a reasonable period, you will reach or exceed the limit of those benefits that have monetary limits.
- We will not apply the excess against medical costs for **treatment** that your **policy** does not cover.

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

These policies have a benefit limit of £1,000 (for each person each **year**) for **out-patient** consultations, **diagnostic tests** and **practitioner**, **therapist**, **physiotherapist** and **acupuncturist** charges.

Example 1	
One	You develop a medical problem and require £600 of **eligible diagnostic tests** – your first claim for that **policy year**.
Two	The £100 excess charge is applied.
Three	We pay £500 towards the £600 cost of **out-patient treatment**, while you pay the £100 excess.
Four	This £600 total claim reduces your £1,000 benefit limit for **out-patient** consultations, **diagnostic tests** and **practitioner**, **therapist**, **physiotherapist** and **acupuncturist** charges to £400.
Then...	Later in the same **policy year**, you suffer a different **medical condition**, incurring costs of £450 for **eligible out-patient** consultations and **diagnostic tests** – £50 more than the **policy's** remaining £400 benefit limit.
So...	We pay £400 towards the cost of **treatment**, and you pay the £50 shortfall.

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

Example 2	
One	You require £1,200 of **eligible diagnostic tests** but the **policy** limit is £1,000.
Two	So, we pay £1,000 for the **treatment** – less the £100 excess – giving a total of £900.
Three	You pay the remaining £200 not covered by the **policy** plus the £100 excess making a total of £300.
So...	Leaving no further benefit for **out-patient** consultations, **diagnostic tests** or **practitioner**, **therapist**, **physiotherapist** and **acupuncturist** charges for the rest of the **policy year**.

11 ADVICE AND SUPPORT LINES

Saga GP Service

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

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

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

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

Your call will be answered by a specially trained operator. The operator will take some details from you and arrange for a GP to call you back at a convenient time. If you'd like to book an appointment online, you can do this via www.saga.co.uk/GPService

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

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

Saga GP Service – 0800 027 1333

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

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

Please remember to have your policy number to hand before you call. You can also book an appointment online via www.saga.co.uk/GPService

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

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

Saga Health Information Line

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

Whether you are calling because you have late night worries about a child's health, or because you have concerns about an ongoing medical condition that you would like to discuss; or maybe you have some questions following a consultation that you did not think to ask at the time, then it's likely that the Saga Health Information Line will be able to provide you with the help you need.

The team of nurses, pharmacists, counsellors and midwives is on hand to give you the benefit of their expertise. They can answer your questions and give you all the latest information on specific illnesses, treatments and medications as well as details of local and national organisations.

They can also send you free fact sheets and leaflets on a wide range of medical issues, conditions and treatments, and will happily phone you back to discuss any further questions you may have from what you have read.

Saga Health Information Line – 0800 17 40 17

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

If calling from outside the UK, phone +44 800 17 40 17 – international call rates apply.

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

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

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

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

12 COMPLAINT AND REGULATORY INFORMATION

Not happy with our service?

We hope you're happy with the service you've received so far and that this continues. However, if you do have a complaint about our services, the most important thing for us is to help you resolve this as quickly and easily as possible. We'll do all we can to address your concerns when they are first raised to us, but if we can't do this, we'll contact you within five working days to acknowledge your complaint and explain the next steps.

Letting us know you're unhappy with our service gives us the opportunity to put things right for you and improve our service for everybody.

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

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

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

For queries and complaints not related to a claim

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

The Customer Relations Department
Saga Services Limited
PO Box 253,
Seaham DO, SR7 1BN
Call: 01303 771160, Fax: 01303 771347 or
Email: services.customer-relations@saga.co.uk

For queries and complaints related to a claim

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

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

Financial Ombudsman Service

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

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

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

How to contact the Financial Ombudsman Service

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

None of these procedures affect your legal rights.

What regulatory protection do I have?

The Financial Conduct Authority

Saga Services Limited is regulated and authorised by the Financial Conduct Authority (FCA). AXA PPP healthcare Limited is regulated by the FCA and also regulated and authorised by the Prudential Regulation Authority (PRA). The FCA have set out rules which regulate the sale and administration of general insurance which we must follow when we deal with you.

AXA PPP healthcare's register number is 202947.
This information can be checked on the FCA website: register.fca.org.uk or by calling 0800 111 6768.

The Financial Services Compensation Scheme

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

What we do with your personal data

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

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

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

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

Much of the personal information Saga and the underwriter of your **policy**, AXA PPP healthcare Limited, hold about you is obtained when you apply for a Saga Health Insurance **policy**, and when a claim is made. This may include medical information we obtain from medical practitioners and other health consultants. We may also obtain information from third party suppliers of information such as credit reference agencies.

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

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

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

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

You should be aware that Saga and AXA PPP healthcare do not supply any information about you to anyone unless we believe it is lawful to do so, or when we are requested to do so by you and have your consent in advance. We may, at our discretion, appoint third parties to service the **policy** and claims, including other companies

based outside the European Economic Area, and which may be in a country that does not offer the same level of data protection as within the European Economic Area. We will always use every reasonable effort to ensure sufficient protections are in place to safeguard your personal information.

Marketing policy

Saga may share your personal information, and your medical data, with other Saga Group (Saga plc and its subsidiaries) companies. Saga uses the data they collect from you, including sensitive personal data, to contact you and personalise their communication. Saga and AXA PPP healthcare also use it for administrative purposes to provide the service you requested and for preparing quotations. If Saga has obtained your permission to do so, they will also contact you by post, telephone, email or other means to tell you about offers, products and services that may be of interest to you. At any time you can opt out of receiving such information, revise the products you would like to hear about or change the method they use to communicate with you. You can update these preferences by calling 0800 056 9271. For further information about how the Saga Group uses your personal information, please visit www.saga.co.uk/privacy-policy or contact the Saga Group Data Protection Officer by email: data.protection@saga.co.uk or post: Saga Services Limited, 3 Pancras Square, London N1C 4AG

Obtaining a copy of the information we hold about you

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

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

If you want to contact Saga or AXA PPP healthcare to exercise any of your rights just call 0800 056 9271 (for Saga) or 0800 027 1331 (for AXA PPP healthcare). Alternatively you can write to Saga at: Saga Services Limited, 3 Pancras Square, London N1C 4AG or AXA PPP healthcare at: Data Protection Officer, AXA PPP healthcare Limited, Jubilee House, Vale Road, Tunbridge Wells, Kent TN1 1BJ.

Crime prevention and detection and legal requirements

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

Keeping information

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

Future underwriter changes

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

Legal rights and responsibilities

12.1 Your rights and responsibilities

(a) Your **policy** is an annual insurance contract and lasts for one **year**. We will pay for covered costs under the terms of this **policy** when **treatment** takes place in a period for which premium has been paid. We will not pay any costs for **treatment** or services received after the end of your period of cover under the **policy**. We will not pay for **treatment** that happens outside your period of cover even if we had pre-authorised it during your period of cover under the **policy**.

The provision of the **treatment** itself, including the date(s) of the **treatment**, will be the subject of a separate agreement between you and your **treatment** provider. Prior to the end of any **policy year** Saga will write to the **policyholder** to advise on what terms the **policy** will continue, provided the **policy** you are on is still available. If Saga does not hear from the **policyholder** in response they will renew your **policy** on the new terms. Where you have opted to pay premiums by Direct Debit, Saga may continue to collect premiums by such method for the new **policy year**. Please note that if Saga does not receive your premium, you will not be covered. If the **policy** you were on is no longer available we will do our best to offer you cover on an alternative **policy**.

(b) You must make sure that whenever you are required to give us any information all the information you give us and Saga is sufficiently true, accurate and complete so as to present to us fairly the risk we are taking on. If we discover later it is not then we can cancel the **policy** or apply different terms of cover in line with the terms we would have applied had the information been presented to us fairly in the first place.

(c) You and we are free to choose the law that applies to this **policy**. In the absence of an agreement to the contrary, the law of England and Wales will apply. The terms and conditions and all other information concerning this insurance are supplied in the English language and we undertake to communicate in this language for the duration of the **policy**.

(d) You must write and tell Saga if you change your address.

(e) Only the **policyholder** and we have legal rights under this **policy** and it is not intended that any clause or term of this **policy** should be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999, by any other person including any **family member**.

(f) You must pay your premium when it is due.

(g) The **policyholder** may cancel this **policy** by contacting Saga during the 14 day cooling-off period. The 14 day cooling-off period begins on either the start date or renewal date of the **policy** or the day that the **policyholder** receives the full **policy** terms and conditions, whichever is the later. The 14 day cooling-off period also applies from each renewal date. If the **policy** is cancelled during the 14 day cooling-off period we will return any premium paid for the **policy** providing no claims have been made on the **policy** in relation to the period of cover before cancellation (being no more than 14 days' cover). The terms and conditions and all other information concerning this insurance are supplied in the English language and we undertake to communicate in this language for the duration of the **policy**. If the **policyholder** does not cancel the **policy** during the 14 day cooling-off period the **policy** will continue on the terms described in your Policy Book for the remainder of the **policy year**.

(h) After the 14 day cooling-off period the **policyholder** may cancel this **policy** at any time by notifying us verbally or in writing. Providing no claims have been made in the **policy year**, we will return any premium paid in relation to any unused period of cover. If you incur **eligible** claims in the **policy year**, and cancel before or after the 14 day cooling-off period, we reserve the right to require the **policyholder** to pay for

the services we have actually provided in connection with the **policy** to the extent permitted by law and any return of premium is subject to this. You may be entitled to a return of premium for any unused period of cover by paying us back for any claims paid during the **policy year**.

If for any reason you decide to cancel your **policy**, let Saga know by calling or writing to Saga's Customer Care Team, Saga Services Limited, PO Box 253, Seaham DO, SR7 1BN. They will then write to you and confirm when your **policy** has been cancelled.

12.2 Saga and AXA PPP healthcare's rights and responsibilities

(a) Saga will tell the **policyholder** in writing the date the **policy** starts and any special terms which apply to it.

(b) We can refuse to add a **family member** to the **policy** and we will tell the **policyholder** if we do.

(c) We will pay for **eligible** costs incurred during a period for which the premium has been paid.

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

(e) If you break any of the terms of the **policy** which we reasonably consider to be fundamental, we may (subject to 12.2(f)) do one or more of the following:
- refuse to make any benefit payment or if we have already paid benefits we can recover from you any loss to us caused by the break;
- refuse to renew your **policy**;
- impose different terms to any cover we are prepared to provide;
- end your **policy** and all cover under it immediately.

(f) If you (or anyone acting on your behalf) make a claim under your **policy** knowing it to be false or fraudulent, we can refuse to make benefit payments for that claim and may declare the **policy** void, as if it never existed. If we have already paid benefit we can recover those sums from you. Where we have paid a claim later found to be fraudulent, (whether in whole, or in part), we will be able to recover those sums from you.

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

(h) We can change all or any part of the **policy** from any renewal date. We will give you reasonable notice of changes to your **policy** terms.

13 GLOSSARY

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

Some sections of this Policy Book have defined terms specific to that section, in which case the definition is provided in the relevant section rather than in the main glossary.

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

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

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

Acupuncturist – a medical practitioner who specialises in acupuncture and is registered under the relevant Act, or a practitioner of acupuncture who is a member of the British Acupuncture Council (BAcC), and who, in all cases, meets our criteria for acupuncturist recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise as an acupuncturist for benefit purposes in that field for the provision of **out-patient treatment** only. A full explanation of the criteria we use to decide these matters is available on request.

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

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

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

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

Chronic condition ◊ – a disease, illness, or injury that has one or more of the following characteristics:
- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.

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

and has either:
- been approved by NICE (the National Institute for Health and Care Excellence) as a **treatment** which may be used in routine practice; or
- been proven to be effective and safe for the **treatment** of your **medical condition** through high-quality clinical trial evidence (full criteria available on request).

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

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

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

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

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

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

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

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

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

Family member – (1) the **policyholder's** current spouse or civil partner or any person (whether or not of the same sex) living permanently in a similar relationship with the **policyholder**.

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

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

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

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

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

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

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

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

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

Medical device – any instrument, apparatus, appliance, software implant, reagent, material or other article intended by the manufacturer to be used, alone or in combination, for human beings.

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

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

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

Physiotherapist – a medical practitioner who practises physiotherapy and who meets our recognition criteria for benefit purposes in their field of practice, and who we have told in writing that we currently recognise as a physiotherapist for benefit purposes. When such persons provide such services to you as part of your **in-patient** or **day-patient treatment**, those services will form part of the private **hospital** charges.

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

Policy – the insurance contract between you and us.

Its full terms are set out in the current versions of the following documents as sent to you from time to time:
- any application form relating to this policy
- these terms and the **benefits table** setting out your cover

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

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

Practitioner – a practising member of certain professions allied to medicine who, in all cases, meets our recognition criteria for benefit purposes in their field of practice and who we have told in writing that we currently recognise as a practitioner for benefit purposes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Therapist – a medical practitioner with full registration under the Medical Acts, who is a practitioner in osteopathy or chiropractic, is registered under the relevant Act and who, in all cases, meets our criteria for therapist recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise as a therapist for benefit purposes in that field for the provision of **out-patient treatment** only. A full explanation of the criteria we use to decide these matters is available on request.

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

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

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

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

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

14 APPENDIX

MORATORIUM UNDERWRITING

This section applies to policyholders who did not provide their medical history on joining and have chosen the Moratorium method of underwriting for their cover. Your Policy Schedule will indicate if this applies to you. Full information on how the Moratorium method of underwriting works is shown in the section 5 'Existing medical conditions' of this Policy Book.

Frequently asked questions

What is the advantage of Moratorium underwriting?

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

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

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

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

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

You would be covered provided that there were no symptoms evident at the time your policy commenced and it was not a specified condition, as shown in the table under section 5 'Existing medical conditions', nor a pre-existing condition.

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

You would not be covered under a Moratorium for any treatment you would need to have because of the abdominal pain. This is because symptoms were evident when you took out the policy-making this a pre-existing condition.

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

During your first two years of continuous cover with us you would not be covered for any further treatment relating to your knee operation, or the condition for which it was performed. After that time, provided you have been trouble free (see definition under section 5 'Existing medical conditions'), for a consecutive two-year period after joining in relation to your knee problem, you would be covered for further eligible treatment.

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

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

How do regular check-ups affect the Moratorium?

It depends on what check-ups are for. For example:

1) If you have a medical condition before your policy starts and your doctor or specialist recommends that you continue to have check-ups for that medical condition, then we will not cover the cost of private treatment received for your medical condition for a period of two years from the time your policy started. If the medical condition is one of these shown in the pre-existing condition table in section 5 'Existing medical conditions', you would not be covered for it either. Cover would only be available once you have been discharged from care and have no further treatment, medication, special diets or advice for a continuous period of two years.
2) In the same situation described above, if you chose to continue having check-ups for your own peace of mind even though you have been discharged from care, we will cover you for that condition (though not the routine check-ups) after joining, if you are trouble-free for a continuous period of two years after joining from your last appointment to discharge.
3) If you have general health check-ups simply in the interest of maintaining good health and not for any particular condition, we ignore them when applying the restrictions of pre-existing conditions.

Note: We do not pay for check-ups in any of the circumstances described above.

Please note:
The preceding questions and answers provide broad guidance to the operation of the Moratorium method of underwriting. Each claim is dealt with and treated on its own merits. How the clause is interpreted depends entirely on the facts presented. When we receive a fully completed claim form, we will be pleased to tell you whether cover is available before you have treatment.

Will my choice of underwriting method affect my premium?

Choosing between Moratorium and Full Medical Underwriting will not affect your premium.

FULL MEDICAL UNDERWRITING

This option is similar to Moratorium in that we provide cover for new medical conditions that arise after the policy begins. However, when it comes to exclusions for pre-existing and specified conditions, we will base these on the answers you provide in response to our full medical history assessment.

Your Policy Schedule will indicate if this applies to you. Full information on how the Full Medical Underwriting method of underwriting works is shown in section 5 'Existing medical conditions' of this Policy Book.

Frequently asked questions

What is the advantage of Full Medical Underwriting?

The benefit of this option is that we will state, in writing, which medical conditions we will exclude. As with the Moratorium option, we may later cover a pre-existing medical condition if you ask us to review the exclusion and we agree to remove it. Important note: If necessary, we may ask your doctor for any further information required to help us determine which medical conditions we should exclude from your policy.

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

You would be covered provided that there were no symptoms evident at the time your policy commenced, and it was not a specified condition, as shown in the table under section 5 'Existing medical conditions', or a pre-existing condition.

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

You would not be covered with Full Medical Underwriting for any treatment you would have to have because of the abdominal pain. This is because symptoms were evident when you took out the policy – making it a pre-existing condition.

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

During your first two years of continuous cover with us you would not be covered for any further treatment relating to your knee operation, or the condition for which it was performed. After that time, provided you have been trouble-free (see definition under section 5 'Existing medical conditions') for a consecutive two-year period in relation to your knee problem, if you ask us to review your exclusion, we may be able to offer any cover for the knee condition.

How do regular check-ups affect my Full Medical Underwriting?

It depends what the check-ups are for. For example:

1) If you have a medical condition before your policy starts and your doctor, or specialist, recommends that you continue to have check-ups for that medical condition, then we will not cover the cost of private treatment received for that medical condition for a period of two years from the time your policy started. If the medical condition is one of those shown in the pre-existing condition table in section 5: 'Existing medical conditions', you would not be covered for it either. Cover will only be available once you have been discharged from care and have no further treatment, medication or advice for a continuous period of two years after joining, and if we have agreed to remove the exclusion.
2) In the same situation, if you choose to continue having check-ups for your own peace of mind even though you have been discharged from care, we will cover you for the condition (but not the routine check-ups) if, after joining, you are trouble-free for a continuous period of two years from your last appointment prior to discharge.
3) If you have general check-ups simply to maintain good health, and not for any particular medical condition, we ignore them when applying the restrictions for treatment of pre-existing conditions.

Will my choice of underwriting method affect my premium?

Choosing between Full Medical Underwriting and Moratorium will not affect your premium. However, selecting the Full Medical Underwriting method enables you to declare your medical history up-front making any exclusions clear at the start of your cover.

CONTINUED PERSONAL MEDICAL EXCLUSIONS

This option is only available if you already have cover with another insurer, subject to your medical history over the previous 12 months. Your Policy Schedule will indicate if this applies to you. Full information on how this method of underwriting works is shown in the 'Existing medical conditions' section of this Policy Book.

Frequently asked questions

What is the advantage of Continued Personal Medical Exclusions?

Continuation of cover for pre-existing medical conditions.

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

You would be covered providing the routine visit was for a general check-up and not in respect of any symptoms or pre-existing conditions, and you have no exclusions carried over from your previous insurer in respect of this.

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

In respect of Continued Personal Medical Exclusions, if you planned to see a medical practitioner about this condition when you enrolled with us, an exclusion may apply. We may need to seek further medical information about this condition before we advise about eligibility.

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

If you had treatment in hospital or consulted a specialist in the last 12 months, or had any treatment, consultations, investigations or diagnostic tests planned or pending at the start of cover, then an exclusion is likely to apply for this condition and it would not be eligible for at least two years on the policy. If not and it does not fall under any of the underwriting carried over from your previous insurer, then it would be eligible.

I have continuation cover from my previous insurance company, but you have also added a further term on my policy for treatment I had in the last year. Why is this?

If you had treatment in hospital or consulted a specialist in the 12 months before joining, or had any treatment, consultations, investigations or diagnostic tests planned or pending at the start of cover, then an exclusion is likely to apply for at least two years on the policy. This is in addition to any underwriting that you carried over from your previous insurer and will be detailed on your membership statement. The exclusion(s) may be reviewed two years after the start of cover.

How do regular check-ups affect my cover?

It depends what the check-ups are for and who they are with.

1) If you have only seen your GP for an annual monitoring review of an ongoing condition, then this will not affect your cover. If however, the GP is still actively investigating or stabilising a change or elevation in levels, or a flare up of new symptoms then this would need to be declared when joining and an exclusion for this condition may apply.
2) If you have seen a specialist in the last year or plan to see a specialist, an exclusion for this condition may apply. Any exclusions applied would be reviewable in two years after your enrolment date, subject to a medical report confirming you have been two years free of any medication, treatment, investigations or consultations for this condition.

Note: We do not pay for check-ups in any of the circumstances described above.

Will my choice of underwriting method affect my premium?

If you choose Continued Personal Medical Exclusions, your premium will be more than the Moratorium and Full Medical Underwriting options. This is because both the Moratorium and the Full Medical Underwriting you do not have cover for pre-existing conditions, which you may have under the Continued Personal Medical Exclusions option.

HELPLINES

CLAIMS PERSONAL ADVISERS

For new claims or help with your existing claim

0800 027 1331

If calling from outside the UK

+44 1892 503016 – international call rates apply.

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

SAGA GP SERVICE

To speak to a practising GP

0800 027 1333

24 hours a day, seven days a week.

To book an appointment online

visit **www.saga.co.uk/GPService**

CUSTOMER CARE TEAM

To discuss or make changes to your Saga HealthPlan

0800 056 9273

Or call **+44 2082 822946** from abroad.

Monday to Friday 8.30am-7pm, Saturday 9am-1pm.

SAGA HEALTH INFORMATION LINE

To speak to an experienced healthcare professional

0800 17 40 17

24 hours a day, seven days a week.

Please have your policy number to hand when calling.

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

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

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

Registered Office: 20 Gracechurch Street, London EC3Y 0BG, United Kingdom. Registered in England and Wales No. 3148119.

AXA PPP healthcare Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Saga Services Limited is a wholly owned subsidiary of Saga plc and is registered in England and Wales (Company No. 732602). Registered Office: 3 Pancras Square, London N1C 4AG. Authorised and regulated by the Financial Conduct Authority.

CSB-HE3923

July 2023
PM/PB/SPL/A4/723

SAGA

Experience is everything