Membership Guide.

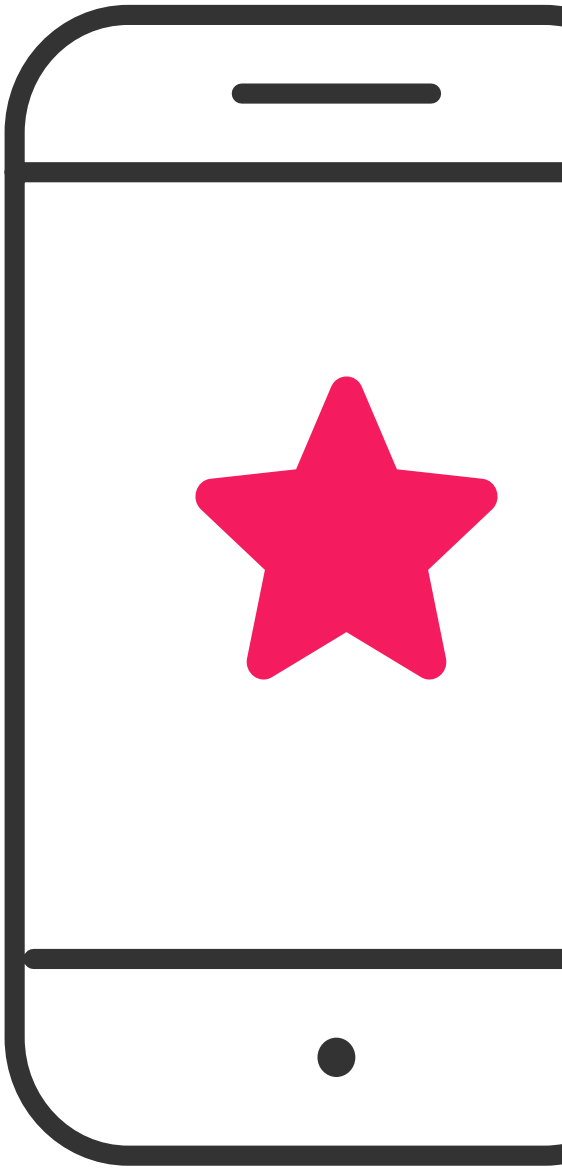
(Your Personal Healthcare plan terms and conditions)

ENTER

Health insurance · Life insurance · Car insurance · Investments

Make a claim and request treatment through the

Care Hub.



- Click on the button or visit vitality.co.uk/member
- Access Care in the Health section in Member Zone or from 'My Health Plan' in the Member app
- From the Care Hub you can:
  - Make a claim
  - Book a Vitality GP consultation
  - Track and monitor existing claims

For more information about the process of requesting treatment under the plan, see "How to arrange treatment" on pages 32 and 33.

VISIT MEMBER ZONE



For the best experience, download this document before reading.

Welcome to Vitality.

Our Private Medical Insurance is not only there when you need **treatment**, but also helps you live a healthier life too. In this document, you will find details of all your plan benefits, as well as how you can get healthier, and be rewarded for doing healthy things.

Together with your application form, membership certificate and hospital list (if you have chosen one), this document lays out the agreement between us. There is a lot of detail in the document, but we have tried to make it easy to read and understand, whether you are reading a paper copy or viewing it online. Please check these documents carefully to make sure all the details are correct, and the plan provides the cover you want.

Some terms have particular meaning. When we say "we", "us" or "our" we mean VitalityHealth, and where we say "you" or "your" we mean the **planholder** or any **insured dependant**. Where the words 'you' or 'your' refer specifically to the **planholder**, we'll say "you (the **planholder**)". Other defined terms are highlighted in bold throughout the document. A full list of these terms and what they mean can be found in "Definitions" on pages 45 to 47.

Thank you for choosing Vitality.

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The Healthy Living Programme

Vitality is insurance that rewards you for being healthy. As well as protecting you when things go wrong, it also helps you lead a healthier life meaning you don't have to claim to be able to benefit. It's the way insurance should be.

We give you advice about keeping well, and discounts to encourage you to get healthier. The more effort you make the more rewards we can offer you.

There are discounts with our health partners, as well as useful tools to help you understand and monitor your health. As you take steps to improve your health you'll earn Vitality points which count towards your Vitality status, helping you to see your progress.

We'll help and encourage you to lead a healthier life by:

1. Helping you understand your health
2. Making it cheaper and easier to get healthy
3. Rewarding you for doing healthy things

There are four statuses, Bronze, Silver, Gold and Platinum. Everyone starts at Bronze and your Vitality status is then determined by the points you build up during your **programme year**, through activities ranging from exercise and healthy eating to health screens and regular **check-ups**.

Your **programme year** begins again on your **programme anniversary** which is set when your first Vitality plan begins (which could be a VitalityHealth, VitalityLife or VitalityInvest plan providing it includes the benefit of the **Healthy Living Programme**) and will correspond to the **annual renewal date** of the plan. Your **programme anniversary** will remain the same for as long as you continuously hold at least one Vitality plan with the benefit of the **Healthy Living Programme**, unless you become a dependant on a plan held by another person, in which case it might change.

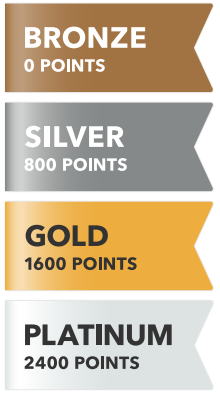
The Vitality status you achieve by the end of a **programme year** will then remain for the whole of the next **programme year**, unless you improve your status.

You can improve your Vitality status by achieving the required number of points to move you from one status to the next; we call this the 'Vitality status threshold'. For example, currently you need 800 Vitality points to reach Silver status and you would need to increase this to 1,600 points to achieve Gold status. When there is more than one adult on a plan the number of points required to reach each status is increased.

Your Vitality status can go down at each **programme anniversary** if the number of Vitality points you earn during that **programme year** isn't enough to maintain the status you previously achieved. Vitality status can also change midway through the **programme year** as new adult dependants are added or removed. You and your **insured dependants** must be 18 or over to benefit. For full details on how it all works and the benefits you can enjoy, please log on to the Member Zone.

See "How the Healthy Living Programme can change" section on page 38 for more details on how the programme can change over time.

There are four statuses which are determined by the points you build up, through activities ranging from exercise to regular check-ups.



Your benefits at a glance

This section provides a summary of what you are covered for. The benefits shown on pages 9 and 10 are included automatically as part of your Core Cover. The benefits shown on pages 11 and 12 are cover options which only apply to you if you (the **planholder**) chose to add them. This will be shown on your membership certificate.

Some benefit limits depend on the option you have chosen. We have highlighted where this applies, as you will need to refer to your membership certificate.

There is more detail on your benefits in "Your benefits explained" on pages 13 to 17, and we have indicated which sections to refer to. Your benefits for **cancer** are listed separately in "Advanced Cancer Cover" on pages 18 to 21.

There are also some things your plan does not cover, which are listed in "Exclusions – what's not covered" on pages 26 to 29. Also, there are some conditions you may not be covered for immediately, or at all, due to the terms on which you took your plan. This is explained in "Acceptance terms" on pages 30 and 31.

Benefit	What's covered	Benefit limit	Further information
Primary care	Video consultations with a **Vitality GP**	Full Cover	Please refer to the 'Your benefits explained' section, under "Primary care" on page 16
	Face-to-face consultations with a private **GP** in our network	See membership certificate	
	GP Advice Line	Available 24hrs	
	Medication prescribed by a **Vitality GP** or private **GP** in our network, for **treatment** of an **acute condition**	Up to £100 per **plan year**	
	Minor **diagnostic tests** ordered by a **Vitality GP** or private **GP** in our network		
Hospital fees	**In-patient** and **day-patient treatment** in a **hospital** eligible under your plan: • accommodation, nursing, and drugs given for immediate use in **hospital** • **critical care** • operating theatre charges, surgical dressings and drugs • surgical appliances needed as a vital part of an operation • **diagnostic tests**, including pathology, radiology, and CT, MRI and PET sans • **physiotherapy**	Full cover	Please refer to the 'Your benefits explained' section, under "Hospital fees and critical care" on page 14
Out-patient surgical procedures	An operation or other invasive procedure carried out as an **out-patient**, and taking place at a **hospital** eligible under your plan or at the **consultant's** specialist consulting rooms (where appropriate): • surgeons' and anesthetists' fees • operating theatre charges, surgical dressings and drugs used during the procedure • any other related and necessary medical **treatment** that takes place on the same day as the surgical procedure	Full cover	Please refer to the 'Your benefits explained' section, under "Out-patient surgical procedures" on page 16
Consultant fees	**Consultant** fees for **in-patient** and **day-patient treatment** that takes place at a **hospital** eligible under your plan: • surgeons' and anesthetists' fees for operations and surgical procedures performed as an **in-patient** or **day-patient** • physicians fees and other **consultant** appointments	Full cover	Please refer to the 'Your benefits explained' section, under "Consultant's fees" on page 13
Private ambulance	The use of a **private ambulance** for transfer between **hospitals**, whether NHS or private, if a **consultant** recommends it as medically necessary	Full cover	Please refer to the 'Your benefits explained' section, under "Private ambulance" on page 17
NHS hospital cash benefit	A cash amount payable for eligible **in-patient treatment** that you choose to have as a non-paying NHS patient even though you could have had the **treatment** in a private facility	£250 per night up to a maximum of £2,000 per **plan year**	Please refer to the 'Your benefits explained' section, under "NHS hospital cash benefit" on page 15
	A cash amount payable for eligible **day-patient treatment** that you choose to have as a non-paying NHS patient even though you could have had the **treatment** in a private facility	£125 per day up to a maximum of £500 per **plan year**	
Childbirth cash benefit	A cash amount payable on the birth of a child or in the case of legal adoption	£100 per child	Please refer to the 'Your benefits explained' section, under "Childbirth cash benefit" on page 13

Benefit	What's covered	Benefit limit	Further information
Parent accommodation	Accommodation for you (the **planholder**) or your insured husband, wife or partner to stay with your insured child, while they are receiving **in-patient treatment** in a **hospital** eligible under your plan	Full cover when the insured child is aged under 14	Please refer to the 'Your benefits explained' section, under "Parent accommodation" on page 16
Pregnancy complications	**In-patient** and **day-patient treatment** at a **hospital** eligible under your plan for the following conditions and directly associated complications: • ectopic pregnancy • miscarriage • missed abortion • stillbirth • postpartum haemorrhage • retained placental membrane • hydatidiform mole	Full cover	Please refer to the 'Your benefits explained' section, under "Pregnancy complications" on page 16
Oral surgery	**Treatment** at a **hospital** eligible under your plan for the following oral surgical procedures only: • reduction of facial and mandibular fractures following an accident • surgical removal of impacted teeth, or partially erupted teeth, causing repeated pain or infections, and complicated buried roots • infections causing facial swelling requiring surgical drainage • removal of cysts of the jaw • apicectomy	Full Cover	Please refer to the 'Your benefits explained' section, under "Oral surgery" on page 15
Rehabilitation	**In-patient** or **day-patient rehabilitation treatment** following a stroke or serious brain injury.	21 days per condition	Please refer to the 'Your benefits explained' section, under "Rehabilitation" on page 17
Home nursing	The services of a qualified **nurse** for skilled nursing care at home, following eligible **in-patient treatment**	Full cover	Please refer to the 'Your benefits explained' section, under "Home nursing" on page 14
Talking therapies	Mental health therapy, such as cognitive behavioural therapy (CBT) or counselling, undertaken as an **out-patient**, and arranged through our mental health panel	See membership certificate	Please refer to the 'Your benefits explained' section, under "Mental health treatment" on page 14
Weight loss surgery	Weight loss surgery in specified circumstances: • gastric banding • gastric bypass • gastric sleeve	75% of the costs	Please refer to the 'Your benefits explained' section, under "Weight loss surgery" on page 17
Corrective surgery	Corrective surgery in children and young adults, in specified circumstances: • Removal of port wine birthmarks on the face • Ear reshaping (pinnaplasty) • Breast reduction, including **treatment** for excessive male breast tissue (gynaecomastia)	75% of the costs	Please refer to the 'Your benefits explained' section, under "Corrective surgery" on page 13

The following options are only available to you if you (the **planholder**) have chosen them. You are only covered for the cover options that show on your membership certificate, which will also show any limits that apply.

Benefit	What's covered	Benefit limit	Further information
Out-patient Cover	MRI, CT & PET scans	Full Cover	Please refer to the 'Your benefits explained' section, under "Out-patient Cover" on page 15
	Physiotherapy undertaken within our network of providers	Full Cover	
	Physiotherapy from a therapist not in our network	See membership certificate	
	Specialist consultations	See membership certificate	
Out-patient Diagnostic Cover	**Diagnostic tests**, such as pathology, X-rays, ultrasound scans and ECGs	See membership certificate	Please refer to the 'Your benefits explained' section, under "Out-patient Cover" on page 15
Mental Health Cover	**In-patient** and **day-patient treatment** in any psychiatric **hospital** eligible under your plan: accommodation, nursing, drugs prescribed on a ward, **diagnostic tests** and **consultants'** fees	28 days per **plan year**	Please refer to the 'Your benefits explained' section, under "Mental health treatment" on pages 14 and 15
	Out-patient treatment including: • **consultant** appointments, electroconvulsive therapy (ECT) and **diagnostic tests** • consultations with a **clinical/counselling psychologist** upon **GP** referral • appointments with a mental health therapist where **treatment** is agreed as clinically appropriate by a **consultant** psychiatrist	£1,500 per **plan year**	
	Out-patient talking therapies arranged through our mental health panel. These include: • cognitive behavioural therapy (CBT) • eye movement desensitisation reprocessing therapy (EMDR) • counselling	Full Cover	
Therapies Cover	The following therapies or consultations after referral by a **GP** or **consultant**: • **chiropractic** • **osteopathy** • **chiropody/podiatry** • **acupuncture** • **homeopathy** • consultations with a **dietician**	Full cover (maximum of two consultations with a **dietician** each **plan year**)	Please refer to the 'Your benefits explained' section, under "Therapies Cover" on page 17

Benefit	What's covered	Benefit limit	Further information
Optical, Dental and Hearing Cover	Dental **check-ups**, X-rays of the mouth and jaw, and routine scaling and polishing	£100 per **plan year**	Please refer to the 'Your benefits explained' section, under "Dental care" on pages 13 and 14
	Dental procedures such as fillings, crowns and root **treatment**	80% of the costs up to £400 per **plan year**	
	Treatment by a **dentist** following an accidental dental injury	£2,500 per claim (max 2 claims per **plan year**)	Please refer to the 'Your benefits explained' section, under "Dental accident" on page 13
	Sight tests and new prescription glasses or contact lenses supplied by our network provider	£500 per **plan year**	Please refer to the 'Your benefits explained' section, under "Optical care" on page 15
	Sight tests and new prescription glasses or contact lenses supplied by any other optician	80% of the costs up to £300 per **plan year**	
	Hearing tests and new prescription hearing aids	80% of the costs up to £300 per **plan year**	Please refer to the 'Your benefits explained' section, under "Audiological care" on page 13
Worldwide Travel Cover	Cover includes medical expenses, cancellation cover, and loss or theft of personal items, for trips of up to 120 days.	See membership certificate	Please refer to the Worldwide Travel Cover Membership Guide if you have chosen this option.

Your benefits explained

Audiological care

Benefit is available for hearing tests at a frequency recommended by your audiologist. It also includes new prescription hearing aids required following that hearing test. We will cover a replacement hearing aid after five years. We will cover a different hearing aid in any **plan year** if this is required following a new prescription.

Your acceptance terms do not apply to this benefit, and you will not have to pay your plan **excess**. We will pay 80% of the costs up to £300 per **plan year**.

Full details of how to submit a claim for audiological care can be found by visiting the Care Hub, available through our Member Zone or Member app.

Childbirth cash benefit

To be eligible for this benefit, you must have been covered on the plan for at least 10 months before the birth. If you took out your plan on continued personal medical exclusions (switch) acceptance terms, the time you were covered by your previous insurer will count towards this waiting period. There is no waiting period in cases of adoption.

Consultant's fees

The **consultant** you choose must be recognised by VitalityHealth and eligible under your plan. To ensure this is the case, you must always get authorisation for your **treatment** from us in advance.

Corrective surgery

Some conditions affecting young people may cause emotional and psychological distress. We have contracted with particular consultant groups to provide access to **treatment** that helps treat port wine birthmarks on the face, surgical ear reshaping (pinnaplasty), surgical breast reduction and surgical **treatment** to correct excessive male breast tissue (gynaecomastia). The **treatment** package includes an initial consultation, all necessary tests, the fees of the **hospital**, surgeon and anaesthetist and clinically necessary follow-up appointments with the **consultant**. Where possible, you will be treated in a facility near to you, but some surgery may only be available in London.

We will pay 75% of the costs of the **treatment** package in the following circumstances:

- for removal of port wine birthmarks on the face, the **insured dependant** must be under 5 years of age when the **treatment** starts. We will cover up to ten **treatments** in total.
- for ear reshaping (pinnaplasty), the **insured dependant** must be between 5 and 14 years of age (inclusive) when the **treatment** starts.
- for breast reduction, including **treatment** for excessive male breast tissue (gynecomastia), you (or **insured dependant**) must be aged under 21 years of age at the start of **treatment**, and have a Body Mass Index (BMI) of less than 27 kg/m^2.

The procedure must be authorised by us in advance, arranged by the consultant group nominated by us, and agreed as clinically necessary and appropriate by the **consultant**. Your acceptance terms do not apply to this benefit, but you must have been a member of the plan for at least 12 months before **treatment** begins. You will not be eligible for this benefit if you have previously had the procedure, whether or not this was covered under your Vitality plan. You will not have to pay your plan **excess** in respect of this **treatment**, however, you will need to pay 25% of the costs of the package price agreed with the consultant group. The package price will be determined following the initial consultation. If you decide not to proceed with the procedure, we will cover the cost of the consultation.

Dental accident

This benefit only applies to accidents that occur after your **cover start date**. Benefit is available for the charges of a **dentist** or specialist in dental **treatment** to repair the damage that occurs as a direct result of a **dental accident**. The **dental accident** must have required an emergency dental appointment or an admission to an accident and emergency department of an NHS hospital. You can make a maximum of two claims for this benefit in a single **plan year**.

Benefit is not available for:

- **treatment** that would have been required even if the accident had not taken place
- **treatment** resulting from a **dental accident** caused by engaging in contact sports, unless the proper mouth-guard was worn
- injuries caused by eating and drinking
- normal wear and tear
- **treatment** taking place more than 12 months after the **dental accident** that led to the injury

Dental care

You only have benefit for dental care if you have chosen the Optical, Dental and Hearing Cover option. All dental care must be carried out by a **dentist** or **dental hygienist** in a dental surgery, in accordance with accepted standards of dental practice. NHS (Bands 1, 2 and 3) or private charges are eligible. You can claim for the charges of an endodontist or orthodontist when you have been referred to them by your **dentist** for an eligible **treatment**.

For benefit under this option, 'Dental procedures' means fillings, crowns, inlays, onlays, overlays, bridgework, root treatment, extractions, implants and dentures. It also includes charges for teeth aligners and braces for insured members aged under 18 when the aligner or brace is fitted. In addition, benefit is available for emergency call out fees, by which we mean the extra charge made by a **dentist** to open their surgery out of normal opening hours in order to carry out **treatment** that cannot be delayed until normal opening hours resume.

We will reimburse you for 80% of the costs of dental procedures, providing the **treatment** is clinically necessary. There is no benefit available for:

- treatment for cosmetic reasons, including teeth whitening and bleaching
- veneers
- teeth aligners or braces for members aged 18 or over
- mouth guards, gum shields or other dental appliances
- dental **treatment** resulting from an injury caused while engaging in contact sports, unless the proper mouthguard was worn
- loss or damage to dentures other than whilst being worn
- prescription charges
- dental insurance premiums or the charges for dental payment plans

Your acceptance terms do not apply to this benefit, and you will not have to pay your plan **excess** in respect of this **treatment**. However, you must have undergone a **check-up** with your regular **dentist** and have completed all dental **treatment** recommended in the 15 months before your **cover start date**. If you have not seen a **dentist** in the 15 months before your **cover start date**, then eligibility for this cover will only begin after you have undergone a check-up by a **dentist** and completed all dental **treatment** recommended. This condition will also be reapplied if, after your **cover start date**, you leave a gap of more than 15 months between **check-ups**.

Full details of how to submit a claim for dental care can be found on the Care Hub, available through our Member Zone or Member app.

Home nursing

To be eligible for benefit, all **home nursing** must:

- immediately follow a period of **in-patient treatment** for a condition covered by this plan
- be certified by your **consultant** as necessary for medical (not domestic) reasons
- be skilled nursing care provided at your home, which would otherwise be provided in **hospital** as an **in-patient**
- be given by a qualified **nurse** and carried out under the direction of your **consultant**

There is no benefit available for:

- **home nursing** following **in-patient treatment** for psychiatric and mental health conditions
- **home nursing** for a **chronic condition**
- any charges incurred for domestic or social reasons
- frail care (e.g. care received in a convalescent or nursing home, respite care and domestic support)
- end of life care or palliative care (except for the benefit available under "Advanced Cancer Cover" on pages 18 to 21).

Hospital fees and critical care

Your **treatment** must take place at a **hospital** eligible under your plan, and under the care of a **consultant** recognised by us. To ensure this is the case, you must always get authorisation for your **treatment** from us in advance.

We will pay for **critical care** in a private intensive care ward or private **critical care** ward that:

- follows a scheduled (planned) admission to the same **hospital**, for **treatment** covered by the plan
- is provided in a dedicated **critical care** area, and
- is the most appropriate setting for such **treatment**.

Unless we agreed in advance, we will not pay for **critical care** that:

- follows an unscheduled admission
- follows **treatment** not covered by the plan
- is not medically necessary for the condition being treated
- immediately follows a transfer from another facility, or was likely to be required following the transfer

Mental health treatment

If you have chosen to include 'Mental Health Cover' then all **treatment** must be arranged by a psychiatric **consultant**, following a referral from your **GP**, except:

- **out-patient** consultations with a **clinical/counselling psychologist** who you were referred to by your **GP**
- **treatment** arranged by our mental health panel

Whether or not you (the **planholder**) have chosen to include 'Mental Health Cover', you can refer yourself for talking therapy, without a referral from a **GP**. The number of sessions you are eligible for is stated on your membership certificate. However, you must contact us before undergoing **treatment**, so we can arrange for you to see a mental health therapist on our panel. You can find more information on the options available to you, and how to arrange your **treatment**, by visiting the Care Hub, available through our Member Zone or Member app.

Due to the nature of mental illness, it may become apparent over the course of **treatment** that you are suffering from

a **chronic condition**. A full explanation of what this means is contained in the "Exclusions – what's not covered" on pages 26 to 29, however it may result in no further benefit being available for that condition. Where this happens, we will always give you notice before withdrawing cover so that you can make alternative arrangements.

NHS hospital cash benefit

The NHS hospital cash benefit is only available for **treatment** that would have been eligible under your plan had you decided to be treated privately. If you are admitted to hospital in an emergency, no benefit will be payable for any part of the admission. If you choose to transfer to a private **hospital** for part of your **treatment**, there is no benefit payable for any of the nights you spent as a non-paying NHS patient. If you are admitted as an **in-patient** after midnight, then no benefit is payable for that first night spent in **hospital**.

Your plan also includes cash benefits if you have **treatment** for **cancer** as a non-paying NHS patient (see the "Advanced Cancer Cover" section on pages 18 to 21 for further details). If you have already claimed a cash benefit for **treatment** of **cancer** that took place on the same day or night, you can't also claim the NHS hospital cash benefit.

Optical care

Benefit is available for sight tests at a frequency recommended by your optometrist. It also includes new prescription glasses or contact lenses required following that sight test.

For glasses, we will reimburse you for the cost of a single pair of frames, lenses (including bifocals or varifocals, where necessary), and lens modifications (coating, tinting or thinning). The cost of prescription sunglasses are eligible, but you will not also be able to claim for a pair of regular glasses for the same prescription. You can claim for one repair to your existing prescription glasses in each **plan year**. No benefit is available for replacement glasses on the same prescription, and we will not reimburse you for accessories such as cases or cloths, unless they are included at no extra charge when purchasing the frames.

For contact lenses, benefit is available for a one-year's supply following a sight test and the issue of a new prescription. This can include charges made under an eye care plan, but we will only reimburse you for the lenses you have already received. No benefit is available for contact lens **check-ups** or contact lens solutions.

Your acceptance terms do not apply to this benefit, and you will not have to pay your plan **excess**. However, you will not be eligible for new glasses or contact lenses for prescriptions issued prior to your **cover start date**. We have partnered with a leading optician network to provide you with additional benefits. If you use our network partner for your sight tests, and glasses or contact lenses (where required), you can claim up to £500 per **plan year** and we will reimburse you in full. If you use a different provider, we will pay 80% of the costs up to £300 per **plan year**. You cannot claim any more than £500 in total in any single **plan year**. More information about our network provider, along with details on how to make a claim, can be found on the Care Hub, available through our Member Zone or Member app.

Oral surgery

Benefit is only available for the specific procedures listed in the benefit table for oral surgery in the "Your benefits at a glance" on pages 8 to 12. No benefit is available for:

- any other dental **treatment**, or maxillofacial or oral procedure
- elective surgery to correct conditions of the jaw bones and/or facial skeleton
- procedures to prepare for orthodontics or prosthetic surgery
- **treatment** not provided by an oral surgeon

In addition, you will not be covered under this benefit for any **treatment** following an accident that occurred before your **cover start date**.

Out-patient Cover

You will be covered up to the limit shown on your membership certificate for appointments with a **consultant**, following a referral from a **GP**, along with any **diagnostic tests** they order. If you have a limit on your Out-patient Cover, you may have cover so that **diagnostic tests** (such as pathology, X-rays, ultrasound scans, and ECGs) are covered in full. Your membership certificate will show which options apply to you.

Regardless of the limit, providing Out-patient Cover is included on your plan, you are covered in full for MRI, CT and PET scans. All consultations, tests and scans must take place at a **hospital** eligible under your plan.

Your Out-patient Cover also includes **physiotherapy**. We have agreed tariffs in place with a select panel of physiotherapists across the country. Providing you contact us so we can arrange for you to see a physiotherapist on our panel, we'll cover each **physiotherapy** session in full, it won't be subject to any limits on your Out-patient Cover and we'll pay the provider direct. It is not necessary to obtain a referral from a **GP** if you follow this process.

Physiotherapy arranged by your **consultant** following surgery will also be covered in full and will not be subject to any limits on your Out-patient Cover.

If you arrange your own **physiotherapy** then we'll only pay a set amount per session, it will be subject to any limits

on your Out-patient Cover and you'll have to pay the provider direct yourself including making up any shortfall. You can find more details of the claims process, and the amounts we'll pay if you go out of network, by logging on to the Member Zone.

Out-patient surgical procedures

This benefit relates only to the surgical procedure. Any **out-patient** consultations, scans and **diagnostic tests**, and any **treatment** that is not a surgical procedure, will be covered under your Out-patient Cover benefit (if you have chosen to include this).

Parent accommodation

This cover is to enable one insured parent to stay in the same **hospital** as your insured dependent child, who is aged under 14 years of age, when they are admitted as an **in-patient** to a private **hospital** or an NHS private ward within an NHS Private Patient Unit (PPU). Paediatric conditions are mainly treated in NHS hospitals, though some private **hospitals** still provide **treatment**. If your **insured dependant** goes to an NHS hospital for eligible **in-patient** or **day-patient treatment**, they are eligible for the NHS hospital cash benefit.

Only accommodation costs will be covered, and there is no cover available for personal expenses, including meals.

Pregnancy complications

Benefit is only available for complications of pregnancy arising from the specific conditions listed under Pregnancy complications in the "Your benefits at a glance" section on page 10.

No benefit is available for:

- any other complication of pregnancy
- antenatal care
- normal pregnancy and childbirth
- intrauterine fetal surgery and transfusions
- investigation and **treatment** of recurrent miscarriages
- **hospital** charges and **consultants'** fees not directly related to eligible **treatment** (as listed in the benefit table for Pregnancy complications in the "Your benefits at a glance" section on page 10).

In addition, you will not be covered under this benefit for any complication of pregnancy or directly **related condition** that the mother was aware of at her **cover start date**.

Primary care

In order to use the video consultation service, you will need access to an Apple or Android-compatible mobile phone or tablet device. The **Vitality GP** app is available to download for free from the App store and Google Play. Log into the Member Zone to find out more.

Video consultations can be booked up to 48 hours in advance, with appointments available between 8am and 8pm Monday to Friday, and between 8am and 4pm on Saturdays.

During your consultation, the **Vitality GP** will capture information relating to your condition and the outcome of the consultation. This will be recorded securely in the app. You may choose for this information not to be shared with us. However, if you are issued with a prescription, or you are referred for further **treatment** that we cover you for, certain information will be shared with us so we can process your claim.

We reserve the right to charge £25 for each consultation that is missed, or cancelled less than 4 hours prior to the appointment time. Inappropriate use of the service, or aggressive or threatening behaviour towards the **Vitality GP**, may result in your access to the **Vitality GP** being withdrawn.

To book a face-to-face **GP** consultation, you will need to follow the booking process on the Member Zone. There will be a co-payment for each face-to-face **GP** consultation. Please check your membership certificate for details of any limits and co-payments that apply. There is no benefit available for the fees of a private **GP** that is not a **Vitality GP**, or a **GP** not in our private **GP** network.

Should the **Vitality GP**, or a private **GP** in our network, refer you for minor **diagnostic tests** or issue a prescription that is eligible for benefit and that you decide to fulfil at your own pharmacy, you will need to pay for these yourself. We will reimburse you from your primary care benefit, up to your benefit limit. If the prescription is fulfilled through our partner pharmacy then, providing you have sufficient benefit remaining, we will settle the bill directly.

We don't pay for minor **diagnostic tests** that are not ordered by a **Vitality GP**, or a private **GP** in our network. If the **GP** refers you to a **consultant** at the same time as they order the **diagnostic tests**, then the cost of those tests will be deducted from your Out-patient Cover limit, if Out-patient Cover is included on your plan. We also don't pay for private prescriptions issued by anyone other than a **Vitality GP** or a private **GP** in our network, and the prescription will not be eligible for benefit if it is:

- a routine or repeat prescription
- available from a pharmacy as an over-the-counter medication
- a drug which has been prescribed during the last month (unless it is to complete a short course of **treatment**)
- for protection against disease when travelling abroad (including vaccinations) – but you may have benefit for this if you have our Worldwide Travel Cover.
- a supplement or feed (e.g. infant formulas)

The GP Advice Line is a 24 hour phone line giving you access to medical advice seven days a week, 365 days a year. You can use this service if you want advice on general health topics or you are unsure whether to seek emergency **treatment**. However, they will not have any details about you in advance, and they will not be able to refer you to a **consultant** or prescribe medication. If you think you require **treatment** for a specific condition, you should arrange a video consultation with a **Vitality GP** or book a face-to-face consultation with a private **GP** in our network.

Private ambulance

Use of an ambulance is covered for private transfers between **hospitals**, whether NHS or private. This use is limited to paid services provided by independent companies or the NHS. It is limited to medically necessary transfers where there is a reasonable medical need for the action to be taken. Transfers for non-medical reasons will not be covered.

Rehabilitation

This benefit provides you with up to 21 days of **in-patient** or **day-patient rehabilitation treatment** following a stroke or serious brain injury. The **treatment** must:

- immediately follow a period of **in-patient treatment**
- start no more than two months after the initial diagnosis or date of injury
- be undertaken in a rehabilitation unit at a recognised rehabilitation facility

Therapies Cover

The therapy provided must be used for **treatment** of an **acute condition** following referral by a **GP** or **consultant**. All practitioners must be recognised by us, have adequate experience and indemnity insurance, must be registered with the appropriate authority and be a member of a speciality organisation. Our list of criteria for entry for all providers is available on request and on our website.

Weight loss surgery

Weight loss surgery is sometimes recommended to help treat severe obesity when other non-surgical treatments have failed. We have contracted with particular consultant groups to provide access to three types of weight loss surgery – gastric banding, gastric bypass and gastric sleeve. The **treatment** package includes an initial consultation, all necessary tests, the fees of the hospital, surgeon and anaesthetist and clinically necessary follow-up appointments with the **consultant** and (where necessary) a **dietician**. Where possible, you will be treated in a facility near to you, but some surgery may only be available in London.

We will pay 75% of the costs of the **treatment** package, providing you are aged 18 or over on the date the **treatment** begins, you have been covered on the plan for at least 12 months, and:

- you have a Body Mass Index (BMI) of 40 kg/m^2 or above, or
- you have a BMI between 35 kg/m^2 and 40 kg/m^2, and have been diagnosed with at least one of the following conditions:
  - Coronary artery disease
  - Type 2 diabetes mellitus
  - Obstructive sleep apnoea (OSA)
  - Obesity hypoventilation syndrome (OHS)
  - Pickwickian syndrome
  - Non-alcoholic fatty liver disease (NAFLD) or Non-alcoholic steatohepatitis (NASH)
  - Hypertension
  - Dyslipidaemia
  - Venous stasis disease

Benefit is not available if you:

- have reversible endocrine or other disorders that can cause obesity; or
- are receiving **treatment** for drug or alcohol addiction, or where there is evidence of current **drug abuse** or **alcohol abuse**; or
- have uncontrolled, severe psychiatric illness; or
- have previously had the same or similar procedure, whether or not this was through your VitalityHealth plan

The procedure must be authorised by us in advance, arranged by the consultant group nominated by us, and agreed as clinically necessary and appropriate by the **consultant**. Your acceptance terms do not apply to this benefit, and you will not have to pay your plan **excess** in respect of this **treatment**. However, you will need to pay 25% of the costs of the package price agreed with the consultant group. The package price will be determined following your initial consultation. If you decide not to proceed with the procedure, we will cover the cost of the consultation.

Advanced Cancer Cover

Our Advanced Cancer Cover is included in all Personal Healthcare plans. These benefits have been listed in a separate section to help you understand this important part of your plan. The first part of this section provides a summary of where you can have your **treatment** and your benefits, with further information on some of these benefits detailed later in this section.

We have also provided some examples of how your Advanced Cancer Cover works, in the "How your plan works in practice" on pages 48 to 51.

Where you can have your treatment

You're covered for charges for eligible **treatment** at any **hospital** or specialist **cancer** unit that is eligible under your plan. Please refer to the "Your hospital and treatment options" section on page 23 for more information on the **hospitals** and medical facilities you can choose from.

However, if the specific course of private **treatment** recommended by your **consultant** is expected to cost in excess of £100,000, we reserve the right to direct you to a specific facility for that **treatment**.

You're also covered in full for charges for eligible **treatment** at home that would otherwise have to be delivered in a **hospital**, providing this is given by suitably qualified medical staff recognised by us.

If you are admitted to a hospice for end-stage **cancer**, we will pay a charitable donation to that hospice of £75 for each day you spend there.

Your cancer benefits at a glance

Benefit	What's covered	Benefit limit	Further information
Preventive treatment	Charges for the removal of healthy tissue or organs in order to prevent the occurrence of **cancer**, when: • you have been covered on the plan for a continuous period of three years or more • you have been identified as being at very high risk of developing **cancer** in the affected tissue or organ, either through an assessment of family history, or a genetic test, or both • you have received genetic counselling to help you arrive at your decision • your **consultant** supports the choice you have made	Full Cover	Please refer to "Preventive treatment (cancer)" on page 21
Diagnostic tests	**Diagnostic tests** arranged by your **consultant**	Full Cover	Please refer to "Diagnostic tests (cancer)" on page 21
	MRI, CT & PET scans arranged by your **consultant**		
	Consultant appointments		
Surgery	Surgery for diagnostic reasons	Full Cover	
	Surgery to remove **cancer** cells (a tumour)		
Drug therapies	Chemotherapy (the use of drugs to destroy **cancer** cells), including anti-sickness drugs and oral chemotherapy prescribed by an oncologist	Full Cover (and no time limits)	Please refer to "Drug therapies (cancer)" on page 21
	Hormone therapy and bisphosphonate therapy		
	Biological therapy, immunotherapy and targeted therapy		
Radiotherapy	Radiotherapy to destroy **cancer** cells	Full Cover	
	Radiotherapy given for pain relief		
Monitoring your condition	Medically necessary follow-up tests	Full Cover (and no time limits)	Please refer to "Monitoring your condition (cancer)" on page 21
	Consultant appointments needed to monitor your condition		
Other types of treatment	Stem cell **treatment**	Full cover	
	Reconstructive surgery	Full cover	Please refer to "Reconstructive surgery (cancer)" on page 21
	Medication prescribed by your **consultant** for you to take at home immediately following **in-patient** or **day-patient hospital treatment**	Full cover	
	Scalp cooling **treatment** to minimise hair loss during chemotherapy and radiotherapy	Full cover	
	Wigs, and the restyling of wigs	£300 per condition	
	Mastectomy bras	£200 per condition	
	External prostheses and associated costs	£5,000 per condition	

Benefit	What's covered	Benefit limit	Further information
End of life care	Care to relieve pain and other symptoms	Full Cover	Please refer to "End of life care (cancer)" on page 21
	Home nursing	Up to £1,000 per day for maximum 14 days	
NHS Cash Benefit	We will pay you a cash amount when you choose to have any of the following eligible **treatments** as a non-paying NHS patient, even though you could have had the **treatment** in a private facility: • each night spent in **hospital** receiving **treatment** for **cancer** • each day you are admitted to **hospital** as a **day-patient** for **treatment** of **cancer** • each day that you attend **hospital** for radiotherapy (including your planning session), chemotherapy, biological therapy, immunotherapy or targeted therapy, related to the **treatment** of **cancer**	£100 for each day or night, up to a maximum of £10,000 per person in any **plan year**	Please refer to "NHS cash benefit (cancer)" on page 21

Diagnostic tests (cancer)

Where it is not clear that the **diagnostic tests**, scans and associated consultations are related to **cancer**, then the costs will initially be deducted from your Out-patient Cover limit (if you have chosen to include this option on your plan). Once a diagnosis of **cancer** has been confirmed then the deductions from your Out-patient Cover limit will be reversed. If you haven't included Out-patient Cover on your plan, and have paid for the **diagnostic tests**, scans and associated consultations yourself, we will reimburse you once a diagnosis of **cancer** has been confirmed.

Drug therapies (cancer)

When we refer to biological therapy, immunotherapy and targeted therapy, we mean substances that, regardless of the size of the molecule or the manufacturing process, either:

- aid the body's natural defence system in order to inhibit the growth of a tumour, or
- target the processes in **cancer** cells that help them to survive and grow.

Examples include monoclonal antibodies (MABs) and **cancer** growth blockers.

We will not typically cover the use of drugs that are:

- used outside the terms of their **UK** or European licence; or
- producing insufficient evidence that they are safe and effective for treating your condition, or
- not established clinical practice within the **UK**.

In certain circumstances, we may be able to contribute to the costs of certain **treatments** outside the terms of their licence, or that are not standard clinical practice in the **UK**, but have been shown to be effective and safe. In such cases, we would expect the recommendation for the **treatment** to be made by an appropriate multidisciplinary team (MDT). Please see the "Treatment that is not established medical practice in the UK" section on page 22 for more information.

End of life care (cancer)

We will not cover you under this benefit for the cost of personal care services, home adaptation or the supply of special bedding or other equipment.

Monitoring your condition (cancer)

As **cancer** can sometimes return, we will continue to cover you for tests and consultations to monitor your condition. There is no time limit on how long we will continue to cover these tests and consultations for you, providing:

- the tests remain clinically appropriate
- your cover with us has not ended

NHS cash benefit (cancer)

The NHS cash benefit for **cancer treatment** is separate from the NHS hospital cash benefit that you can claim for any eligible **treatment**. If you are having eligible **treatment** for **cancer** as a non-paying NHS patient, you may claim on either one of these benefits. You may only claim one cash benefit for **treatment** taking place on the same day or night.

Preventive treatment (cancer)

Our plans are primarily designed to help diagnose and treat an eligible condition where symptoms have occurred after your cover under the plan has started. This means we don't cover:

- normal screening such as breast screens
- genetic tests to see if you are susceptible to a certain type of **cancer**
- vaccines, such as the vaccine to prevent cervical **cancer**

However, we do offer discounts on risk assessments for some types of **cancer**. Details can be found on the Member Zone.

We will not cover the costs of chemotherapy or other drugs given for preventive reasons (i.e. where there is no actual diagnosis of **cancer**).

Where preventive surgery is eligible on your plan, we reserve the right to direct you to a specific facility for your **treatment**.

Reconstructive surgery (cancer)

We will cover initial reconstructive surgery necessary following surgery to remove a tumour. We will also cover reconstructive surgery necessary following the removal of healthy tissue for preventive reasons, providing the preventive surgery is eligible on this plan.

The reconstructive surgery must take place within five years of the original surgery to remove the tumour or tissue. If there are immediate complications arising from the initial reconstructive surgery, we will also cover the **treatment** to deal with those complications. However, we will not cover surgery at a later point to correct a reconstruction, regardless of the reason it is required. We will not cover more than one reconstructive surgical procedure to the same part of the body.

Treatment that is not established medical practice in the UK

The plan does not generally cover drugs and **treatment** that is not considered to be established medical practice in the **UK**, or where there is insufficient evidence of safety or effectiveness. This includes drugs that are used outside the terms of their **UK** or European licence or **treatment** that has not been reviewed and approved for general use in the NHS.

However, we may consider a contribution towards the costs of such **treatment** where this is part of a properly controlled **UK** clinical trial or where we believe there is adequate evidence that the **treatment** is effective.

We would expect any **treatment** to be recommended by an appropriate multidisciplinary team (MDT). An MDT is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended **treatment** of individual patients. You must contact us before undergoing **treatment** to check what we will cover.

If we agree to make a contribution towards the **treatment**, we will not:

- pay any costs if the **treatment** would in any event be excluded under the other terms and conditions of the plan
- pay more than the cost of the **treatment** if this is lower than the cost of its nearest equivalent established **treatment**
- pay for any further established **treatment** that you could have had instead
- pay for the **treatment** of any complications arising from the **treatment** or for any further **treatment** you might need as a result
- pay for any costs if there is no alternative established **treatment** in the **UK**.

Your hospital and treatment options

When you need **treatment** covered by the plan, you will be able to choose the medical professional who treats you, and where the **treatment** takes place. The choices available to you will depend on the options chosen by the **planholder**. You must always have your **treatment** approved by us in advance, so you know that you will be covered. See "How to arrange treatment" on pages 32 and 33 for further details.

Consultant Select

We recognise the vast majority of **consultants** working in private practice in the **UK**. To help you make an appropriate choice, we assess all **consultants** for robust clinical practice, excellent **treatment** outcomes and how efficiently they deliver healthcare. Should you need to see a **consultant**, we provide you with a choice of recognised **consultants** to choose from who score highly on these measures, and that are appropriate for your condition and where you live.

Premier Consultants

Some **consultants**, that score highly in our assessment, are designated as Vitality Premier Consultants. These **consultants** will be clearly indicated to you as part of your **treatment** authorisation.

Hospital lists

If you have chosen to add a hospital list to your plan, you are also able to choose a recognised **consultant** working out of one of the **hospitals** and medical facilities on that list. There are two hospital list options:

- **Countrywide:** this includes most of the private **hospitals** and NHS private patient units in the **UK**, outside central London, and a more limited choice of **hospitals** and NHS private patient units in central London.
- **London Care:** this includes all the private **hospitals** and NHS private patient units in the **UK**, including those in central London.

The **hospitals** available on each list may change from time-to-time, including during the **plan year**. However, if you are having **treatment** at a hospital that subsequently becomes ineligible on your list, we will make sure you can complete your course of **treatment**. The most recent hospital list can be found at www.vitality.co.uk/health-insurance/hospitals/.

You must make sure that the **consultant** you choose is recognised by us. Whilst the vast majority of **consultants** working privately in the **UK** are recognised by us, you should always get your **treatment** approved by us in advance, to ensure it will be covered.

In the unlikely event that the **treatment** you need is not available at a **hospital** eligible on your plan, we will help you find a suitable facility.

Priority physiotherapy panel

This only applies if you have chosen to include Out-patient Cover on your plan. We have agreed tariffs in place with a select panel of physiotherapists across the country. Providing you contact us so we can arrange for you to see a physiotherapist on our panel, we'll cover each **physiotherapy** session in full, it won't be subject to any limits on your Out-patient Cover and we'll pay the provider direct. It is not necessary to obtain a referral from a **GP** if you follow this process.

Physiotherapy arranged by your **consultant** following surgery will also be covered in full and will not be subject to any limits on your Out-patient Cover.

If you arrange your own **physiotherapy** then we'll only pay a set amount per session, it will be subject to any limits on your Out-patient Cover and you'll have to pay the provider direct yourself including making up any shortfall. You can find more details of the claims process, and the amounts we'll pay if you go out of network, by visiting the Care Hub, available through our Member Zone or Member app.

Mental health panel

You can refer yourself for talking therapy, without a referral from a **GP**. The number of sessions you are eligible for is stated on your membership certificate. However, you must contact us before undergoing **treatment**, so we can arrange for you to see a mental health therapist on our panel. You can find more information on the options available to you, and how to arrange your **treatment**, by visiting the Care Hub.

Premier Consultant Cashback

Our analysis has shown that, on average, patients treated by Premier Consultants have less need to change **consultant**, spend less time in **hospital** and have fewer readmissions to **hospital**. This is good for the patient, and also means the overall costs of **treatment** are lower.

Vitality are a shared-value insurer, which means that when we generate savings we can share them with our members. So when a member on one of our hospital list options chooses a Premier Consultant to provide their care, we provide them with cashback.

The process works as follows:

1. Once you receive a referral to a **consultant** from a **GP**, you should contact us so we can approve your **treatment** (you can also be referred by a **Vitality GP**)
2. You can either use the Care Hub to get your authorisation for **treatment**, or you can call us
3. Once your **treatment** is authorised, you will be offered a choice of **consultants** to provide your care
4. If you choose a Premier Consultant we will provide you with a cash amount.

The amount we provide depends on your Vitality status, as we know that members who live a healthier lifestyle recover more quickly from illness, creating a larger saving. The cashback amount can change from time to time. Please visit Care Hub for more information on the current cashback amounts.

Important notes about the Premier Consultant Cashback:

- The cashback is payable only once per person per condition, based on the first **consultant** you see for that condition.
- For the purposes of calculating the cashback amount due, we will use your Vitality status on the date of your first appointment with the **consultant**. This could be the Vitality status you have earned in the current **plan year**, or the Vitality status you carried over from the previous **plan year**, whichever is the higher.
- Payment will be made once we have received and paid the first invoice from the **consultant**.
- All payments will be made into your (the **planholder's**) bank account, including when the claim is for an **insured dependant**. You (the **planholder)** can update your bank details on the Member Zone.
- Only members with the Countrywide or London Care hospital list option are eligible for the Premier Consultant Cashback. Members with our Consultant Select option are not eligible for the cashback.
- If the first **consultant** you see for your condition is not a Premier Consultant, then no cashback will be payable.
- No cashback is payable for conditions where you do not need to see a **consultant**.
- Occasionally, a Premier Consultant will not be available in your area, for your particular condition. In these cases, we will offer you a choice of other **consultants** who score highly on our assessment, but no cashback will be payable.

Costs you might have to pay yourself

There are certain expenses the plan does not cover, and we want to make you aware of certain costs you will be expected to pay yourself.

Excess

If you have chosen to include an **excess** on your plan, this will be shown on your membership certificate. Your membership certificate will also show whether this **excess** applies 'per claim' or 'per person per **plan year**'.

If you have a 'per claim' **excess**, we will deduct the **excess** from the first invoice we pay (and the next invoice if any **excess** still remains). We will reapply the **excess** if your claim continues for more than one year.

If you have a 'per person per **plan year**' **excess** we will deduct the **excess** from the first invoice for **treatment** taking place in the **plan year** (and the next invoice if any **excess** still remains).

The **excess** should be paid to the relevant person, **hospital** or other facility that provided your **treatment**. We will tell you how much to pay, and to whom. Even if the **treatment** costs are less than the **excess**, you should tell us so we can calculate how much of the **excess** there is left to pay. This will be to your advantage.

The **excess** doesn't apply to:

- consultations with a **Vitality GP** or private **GP** in our network (but you will have to make a co-payment for a face-to-face **GP** consultation). Full details can be found in the "Your benefits explained" on pages 13 to 17.
- minor **diagnostic tests** ordered by a **Vitality GP** or private **GP** in our network
- charges for medication where the prescription has been issued by a **Vitality GP** or a private **GP** in our network
- NHS hospital cash benefit
- Childbirth cash benefit
- Optical, Dental and Hearing Cover (if you have chosen this option – but you will have to pay 20% of the costs of dental procedures and hearing costs, and 20% of your optical costs if you choose not to use our network partner)
- Worldwide Travel Cover (if you have chosen this option – but a £50 excess applies to some sections of this cover)
- Claims under our Weight loss surgery or Corrective surgery benefits, but you will have to contribute 25% to the cost of consultations and package of **treatment**.

Amounts that you pay yourself will not be deducted from any benefit limits on your plan. For examples of how the **excess** deductions are applied, please refer to the "How your plan works in practice" on pages 48 to 51.

Using a hospital not on your plan

If you have not chosen to add a hospital list to your plan, then you must get your **treatment** authorised by us. We will not pay for the **treatment** if we have not authorised it in advance.

If you have added a hospital list to your plan, you must use a **hospital** eligible on your plan. If you use a hospital that is not eligible on your plan, you will have to pay 40% of the costs of the **treatment** (excluding **consultant's** fees) yourself. Even if you do decide to use a hospital not eligible on your plan, you must still ensure the hospital or facility you choose, and the consultant that treats you, is recognised by us. We will not make any payment if the **treatment** takes place in a hospital or facility not recognised by us, or under the care of a consultant not recognised by us.

To avoid any doubt about whether your **treatment** will be covered, you should always have your **treatment** authorised by us in advance.

Personal expenses

If you are admitted to **hospital**, items not directly related to your **treatment** and care will not be covered. Examples include newspapers, additional meals for relatives and phone calls.

Exclusions – what's not covered

In this section, we have set out the medical conditions, **treatment** and tests that we do not cover on the plan. Any consultations, complications or subsequent **treatment** related to these exclusions are also not covered. In addition to these exclusions, there may be some medical conditions that you may not be covered for immediately, or at all, due to the terms on which you took your plan. This is explained in the "Acceptance terms" on pages 30 and 31.

Chronic (long-term) conditions

It is important when buying private medical insurance to understand that it is designed to cover **treatment** for curable (acute) conditions. It does not usually cover long-term **treatment** of **chronic conditions** where the purpose of that **treatment** is primarily just to keep the symptoms under control. Unfortunately, the cost of covering **treatment** of such conditions would make private medical insurance prohibitively expensive. This information is designed to help you understand more about what we mean by **chronic conditions** and when we will and will not cover **treatment** of these.

Please note that we do not include **cancer** as a **chronic condition**. Comprehensive cover for **cancer treatment** is included on your plan.

What is a chronic condition?

A '**chronic condition**' is a disease, illness, or injury that has at least 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.

Your plan covers the cost of **treatment** for **acute conditions**. These are conditions that respond quickly to **treatment** which aims to return you to the state of health you were in before suffering the condition, or which leads to your full recovery.

However, there are certain medical conditions that can end up needing regular consultations and **treatment** over a long period of time. These are the kinds of conditions which we, and the medical profession, usually refer to as **chronic conditions**. We will normally not cover **treatment** of a **chronic condition** if the purpose of the **treatment** is just to control the symptoms.

What does this mean if I fall ill with a chronic condition?

Do be reassured that when you first become ill with a **chronic condition** we will pay for any **consultant** appointments and **diagnostic tests*** you need to have in order to find out the cause of your symptoms. We will also pay for any initial **treatment** you require in order to stabilise your condition.

However, there may come a point when the kind of **treatment** you are receiving appears only to be monitoring your state of health or keeping the symptoms of your condition in check rather than actively curing it. When such circumstances arise, we will discuss the situation with you. We may also ask for your consent to contact a **GP** or **consultant** to obtain further information about your condition and **treatment**. We will always take into account your own specific circumstances and we will never withdraw cover for that condition without giving you a reasonable amount of time to make alternative arrangements.

(*providing your plan covers these)

What if my condition gets worse?

Although we might have withdrawn cover for a **chronic condition**, it does not mean that cover is permanently withdrawn.

If your condition gets worse and you suffer an **acute flare-up of a chronic condition**, then we may cover the **treatment** necessary to return you to the state of health you were in before your condition worsened.

To help you understand what we will cover in relation to **chronic conditions**, we have provided some examples in the "How your plan works in practice" on pages 48 to 51.

Other medical conditions

We will not pay claims relating to:

- **treatment** of HIV/AIDS, or any **treatment** related to this
- **treatment** of **alcohol abuse** or **drug abuse**, or any addiction, and **treatment** of any related medical conditions resulting from these
- **treatment** of any illness or injury arising from illegal or reckless behaviour, including driving while under the influence of drugs or above the legal limit for alcohol
- **treatment** for any condition or injury arising from working offshore in the extraction/refinery of natural/fossil fuels
- **treatment** for any condition or injury arising from working in the armed forces (including the Armed Forces Reservists) whilst on active service or on exercise in the **UK** or abroad
- **treatment** for any condition or injury arising from training for or taking part in **professional sports** or **semi-professional sports**, unless otherwise agreed in writing by VitalityHealth at

your **cover start date**. This exclusion applies to **planholders** and **insured dependants** who have a **cover start date** of 01 March 2016 or after

- **treatment** for injuries arising from participation in high-risk activities. A full list of activities we consider high-risk is available in "Appendix – hazardous activities" on pages 52 and 53.
- **treatment** to maintain your state of health or to monitor your health on a regular basis
- **treatment**, including investigations and assessments, related to developmental problems, behavioural problems and learning difficulties including but not limited to autism, dyslexia and 'Attention Deficit Hyperactivity Disorder' (ADHD)
- **treatment** for myopia (short-sightedness), hypermetropia (long-sightedness), astigmatism or any other refractive error or **treatment** which results from, or is in any way related to, these conditions (except sight tests and glasses or contact lenses covered under the Optical, Dental and Hearing Cover option)
- **treatment** of sleep apnoea (except **treatment** to correct Childhood Obstructive Sleep Apnoea), snoring, insomnia or other sleep disorders or **treatment** which results from, or is in any way related to, these conditions
- **treatment** for dermatochalasis (baggy eyes) or ptosis (drooping) of the eyelid or brow
- **treatment** for obesity and associated conditions, including surgery, or **treatment** which results from, or is in any way related to, this condition (other than **treatment** we have authorised under our Weight loss surgery benefits)
- **treatment** for hearing impairment or deafness that arises as a result of any congenital abnormality, maturity or ageing (except for hearing tests and hearing aids covered under the Optical, Dental and Hearing Cover option). We will only pay for **treatment** for hearing impairment or deafness that arises as a result of an **acute condition** diagnosed within the previous 12 months and after your **cover start date**
- **treatment** to relieve the symptoms commonly associated with physiological or natural changes as a result of ageing e.g. menopause or puberty (other than **treatment** we have authorised under our Corrective surgery benefits)
- **treatment** for complications arising from medical conditions or **treatment** not covered by us. This includes complications arising from experimental **treatment** or **treatment** received overseas
- frail care such as care received in a convalescence or nursing home, respite care, and domestic support.

Treatments, tests and applicances

We will not pay for the following **treatments**:

- the services of a **GP**, except a **Vitality GP** or a private **GP** in our network
- **diagnostic tests** that have been arranged by anyone other than your **consultant**, except minor diagnostic tests ordered by a **Vitality GP** or a private **GP** in our network
- emergency **treatment**, by which we mean:
  - **treatment** in an Accident & Emergency unit or other urgent care centre
  - any admission to **hospital** that was scheduled less than 24 hours in advance

  However, we will cover admission to **hospital** for a surgical procedure that immediately follows an **out-patient** appointment with a **consultant** booked at least 24 hours in advance providing:
  - you are referred to a **consultant** following a face-to-face appointment with a **GP**, or video consultation with a **Vitality GP**, and
  - it was not known that admission would be required when the **consultant** appointment was booked, and
  - your **consultant** appointment does not take place in an Accident & Emergency unit or other urgent care centre, and it is for **treatment** eligible under your plan

  If you are already in hospital, we will only cover eligible treatment that takes place after your consultant has confirmed to us (at your request) that:
  - your vital signs are within normal limits and have been for at least 48 hours, and
  - you do not require critical care (for further information about critical care, please refer to the 'Your benefits explained' section, under "Hospital fees and critical care" on page 14
- immediate admission to **hospital** if you have been repatriated to the **UK** in an emergency
- **treatment**, including surgery, to remove excess or non-diseased tissue whether or not for psychological or medical reasons (other than **treatment** we have authorised under our Weight loss surgery or Corrective surgery benefits, or for the prevention of **cancer** in the circumstances listed in "Advanced Cancer Cover" on pages 18 to 21)
- **treatment** where the primary aim is to improve appearance (cosmetic treatment), whether or not for psychological reasons, or any **treatment** that results from or relates to previous cosmetic treatment, body modifications (e.g. piercings) or reconstructive surgery. However, we will cover certain cosmetic treatment where eligible under our Weight loss surgery or Corrective surgery benefits. We will also cover the initial **treatment**

to restore function or appearance where this is needed as a direct result of an **accidental injury** (except a dental injury) or as a result of **treatment** for **cancer** that occurs after your **cover start date**. Any subsequent related **treatment** will only be covered if intended to cure an **acute condition**

- sex change/gender reassignment or **treatment** which results from, or is in any way related to, sex change/gender reassignment
- hormone replacement therapy
- dental **treatment** (apart from the benefits available under the Optical, Dental and Hearing Cover option)
- regular or long-term dialysis for kidney failure
- organ and whole body part transplants
- stem cell therapy and bone marrow transplant, except where this is for the **treatment** of **cancer**
- **treatment** or drug therapy which, based on established medical practice in the **UK**:
  - is considered to be unproven, or
  - for which no standard **treatment** protocols exist, or
  - for which there is insufficient evidence of safety or effectiveness

  Please see "Treatment that is not established medical practice in the UK" on page 22 for further information
- any **treatment** using a drug not licensed in the **UK** or the use of drugs outside the terms of their licence in the **UK**
- **rehabilitation** following **treatment** except following a stroke or serious brain injury as shown in the rehabilitation table of "Your benefits at a glance" on page 10
- the use of neurostimulators, or any **treatment** connected to the use of them
- **treatment** that's given solely to provide relief of symptoms including psychological support, end of life care or hospice care. However, we will cover end of life **treatment** to help relieve **cancer** symptoms or the side-effects of **cancer treatment**
- **in-patient** care where no medical treatment is being provided, such as needing help with mobility, washing or preparing meals
- any **treatment** for, related to or arising from or as a consequence of:
  - male or female birth control including sterilisation and its reversal
  - any type of contraception
  - termination of pregnancy
  - pregnancy or childbirth, except the conditions shown in your benefits table
  - investigations into or **treatment** of infertility
  - investigations into or **treatment** of impotence or other sexual dysfunction
  - any form of human-assisted reproduction
  - any **treatment** received within three months of birth by a dependant born as a consequence of any form of human-assisted reproduction
- oral and maxillofacial surgery, except those procedures shown in your benefits table
- routine, precautionary or preventive examinations, routine dental, hearing and sight tests (except for the cover available under the Optical, Dental and Hearing Cover option), vaccinations, screenings (including screenings of familial conditions or genetic tests to determine your risk of getting an illness or disease) or preventive **treatment** (but we will cover the removal of healthy tissue for the prevention of **cancer** in specific circumstances. See "Advanced Cancer Cover" on pages 18 to 21 for details)
- **treatment** provided to the **planholder** or **insured dependant** by themselves or a member of their family. We will also not accept a **GP** referral from the **planholder** or **insured dependant**, or a member of their family
- any **treatment** provided by, or undertaken whilst under the care of, a consultant, therapist or complementary medicine practitioner or other clinician who is not recognised by us for the **treatment** being provided. We may not recognise a consultant who, among other reasons:
  - has had their permission to practice suspended or restricted by a professional or regulatory body, or
  - charges more than we think is reasonable compared to other **consultants** with a similar level of expertise

  To become recognised by us, **consultants** must meet our recognition criteria and agree to our terms of recognition
- medical aids or appliances, such as neck collars, splints and foot supports
- mobility aids, such as wheelchairs and crutches
- spectacles, contact lenses or hearing aids (except for the benefit available under the Optical, Dental and Hearing Cover option) or cochlear implants
- the provision or fitting of any external prosthesis (except for the circumstances listed in "Advanced Cancer Cover" on pages 18 to 21)
- drugs and dressings for use at home, following your **treatment** (except for the circumstances listed in "Advanced Cancer Cover" on pages 18 to 21)
- personal expenses, such as newspapers, telephone calls and additional meals.

General exclusions

We will not pay claims relating to:

- **treatment** arising from nuclear or chemical contamination, war, invasion, act of foreign enemy, hostilities (whether war is declared or not), civil war, riot, civil disturbance, wilful violation of the law, rebellion, revolution, military force or coup, act of terrorism

- **treatment** received after the period covered by any premium or after the plan has been cancelled
- **treatment** that is available under a cover option that you have not chosen. Please refer to your membership certificate to check which cover options you (the **planholder**) have selected
- extra accommodation costs for going into **hospital** early or leaving late because of your or your **insured dependant's** domestic circumstances or where there is no required **treatment**
- **treatment** received outside the **UK**, except for emergency **treatment** under the Worldwide Travel Cover, if you have included this on your plan.

Acceptance terms

When you joined VitalityHealth, you were accepted on one of the following terms (also known as underwriting). Your membership certificate will confirm which acceptance terms apply to you. Depending on these terms, there may be some additional medical conditions that you will not be covered for immediately. There may even be some conditions that you will never be covered for.

Full Medical Underwriting

Before starting your cover, you (the **planholder**) completed an application form in which you gave us details about your medical history and that of any **insured dependants**. This information and any additional information supplied by you or a **GP** was then assessed by our medical underwriters. Medical and mental health conditions (and **related conditions**) you currently have or had in the past, that are likely to need **treatment** in the future, are not covered. These are shown on your membership certificate as personal medical exclusions.

If you have failed to provide full and accurate information in answer to the questions asked on application, this may mean that we cannot cover a claim and that we need to correct your acceptance terms by adding personal medical exclusions. In rare circumstances, we may even have to cancel your plan.

Moratorium

Before starting your cover, you did not have to answer any health questions on your application form or undergo a medical examination. Instead, each claim is assessed on the information provided by you and, if necessary, a **GP** (or other medical practitioner) when you claim. We apply a straightforward criteria when assessing your claim.

The Moratorium Clause

We don't pay claims for the **treatment** of any medical condition or **related condition** which, in the five years before your cover started:

- you have received medical **treatment** for, or
- had symptoms of, or
- asked advice on, or
- to the best of your knowledge and belief, were aware existed.

This is called a 'pre-existing' medical condition.

However, subject to the plan terms and conditions, a pre-existing medical condition can become eligible for cover providing you have not:

- consulted anyone (e.g. a **GP**, dental practitioner, optician or therapist, or anyone acting in such a capacity) for medical **treatment** or advice (including **check-ups**), or
- taken medication (including prescription or over-the-counter drugs, medicines, special diets or injections)

for that pre-existing medical condition or any **related condition** for two continuous years after your **cover start date**.

What this means in practice

Your cover for medical conditions can be broken down into three categories:

- Medical conditions that are covered from the first day of your insurance – these are conditions that occur for the first time after you take our your plan
- Pre-existing medical conditions that become eligible for cover after at least two years continuous insurance on the plan. We will cover them if you have not received any **treatment**, advice or medication for that condition for a continuous period of two years after taking out your plan
- Pre-existing medical conditions that we permanently exclude from your cover. We exclude these because you will need regular or periodic **treatment**, advice or medication and you will never be able to remain free of this help for any continuous two-year period.

We have provided some examples of how the moratorium clause works in the "How your plan works in practice" on pages 48 to 51.

What is a related condition?

A **related condition** is any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury. It could be deemed to be an underlying cause of, or directly caused by, another medical condition. For example: high blood pressure and heart disease; recurrent sore throats and tonsillitis.

Continued Personal Medical Exclusions (Switch)

This is where you've been covered by another insurance plan and you (the **planholder**) applied to join us on the basis of continuing with the underwriting terms that applied to you and your **insured dependants** with that other insurance plan. You completed a short health questionnaire and we accepted you on one of the following bases:

Where you were previously **medically underwritten**:

- either exactly the same personal medical exclusions that applied to you and your **insured dependants** under your previous insurance plan continue to apply under this plan, or
- the same personal medical exclusions applied to you and your **insured dependants** by your previous insurance plan continue to apply under this plan and additional personal medical exclusions imposed by us also apply

Where you were previously subject to a moratorium clause

- either our moratorium clause applies but backdated to when your cover first started with your previous insurer, or
- our moratorium clause applies backdated to when your cover first started with your previous insurer and additional personal medical exclusions imposed by us apply from your **cover start date** with us.

If you were previously covered on a 'medical history disregarded' basis, then no personal medical exclusions were applied to your previous plan. This will continue to be the case under this plan unless, on assessment of the answers you gave on the health questionnaire, we applied personal medical exclusions. If this is the case they will be shown on your membership certificate.

Medical History Disregarded

This underwriting method means that we have not asked for any details of your health history, so you have not been **medically underwritten** and no personal medical exclusions have been applied to your cover. However this does not affect the remaining terms and conditions listed in this document, which will continue to apply. This method of underwriting will usually only apply to newborn babies, subject to the joining requirements set out in the "Membership" on page 41.

Reviewing Personal Medical Exclusions

Personal medical exclusions can, in some cases, be reviewed in the future if you ask us to do so following a minimum of 12 months cover with us and within 30 days of your **annual renewal date**. If we require medical evidence to support the review you will have to pay for this. However, we will not review or remove any personal medical exclusion for a **chronic condition**.

Important notes about your acceptance terms

If you have failed to provide full and accurate information in answer to the questions asked on application, this may mean one or more of the following:

- we cannot cover a claim
- we need to correct your **medical underwriting** terms by adding personal medical exclusions to you or your **insured dependants**
- we have to cancel your plan
- we need to reclaim the costs of any **treatment** already paid for by us.

If you have joined us on continued personal medical exclusions, please note:

- the benefits, terms and conditions of this plan may be different from those of your previous plan
- we may be unable to authorise any eligible claims if we do not receive your previous insurer's membership certificate.

How to arrange treatment

It is very important for you to contact us before having any **treatment**, so we can ensure the **treatment**, medical practitioner and **hospital** are covered on your plan. Following the conditions and processes outlined below will help ensure that you are not faced with any unexpected costs relating to your **treatment**.

Before you have any treatment

- Ensure you're registered with a **UK GP** and that they have your full medical records. This will help avoid delay in getting your **treatment** authorised.
- Obtain a referral from your **GP** for your **treatment**. You can also obtain your referral from a **Vitality GP** or other private **GP**. Unless you have added a hospital list to your plan, this must be an open referral (i.e. not to a specific **consultant** or therapist). You will not need a **GP** referral for mental health talking therapy and **physiotherapy** (providing you have Out-patient Cover) as long as you arrange these through our panels.
- Contact us so we can authorise your **treatment**. You can do this visiting the Care Hub, available through our Member Zone or Member app. Alternatively, you can call us using the number on your membership certificate. We will not pay for **treatment** we have not authorised in advance.

Getting authorisation for your treatment

More often than not we will be able to take your claim details online, or over the phone, and authorise and arrange your proposed **treatment** at the same time. If you use the **Vitality GP** service to obtain your referral, they may be able to approve your claim and arrange your **treatment**. In some cases, the **Vitality GP** will decide that you need a physical examination before being referred, and will ask you to make an appointment to see your **UK GP**.

Sometimes, particularly if you claim in the first one or two years after joining us, we may need you to send us a fully completed claim form to help us assess your claim. We will normally ask for details of your medical history for at least the previous five years, with sections for both you and your **GP** to complete. We will not pay fees charged by a medical practitioner for completing a claim form, and we will be unable to assess the claim or pay for any **treatment** before we receive the claim form.

We will ask for your consent before we ask the **GP** to complete a claim form. We will also ask for consent if, during your **treatment**, we need a medical report or your NHS medical records from your **GP**, **consultant**, or other medical practitioner involved in your care, in order to confirm that the **treatment** remains eligible. This is in accordance with your rights under the Access to Medical Reports Act 1988. If you do not give your consent, we may not be able to approve your **treatment**. If we do need a report to help us assess or monitor an ongoing claim, we will pay a reasonable fee for that report.

We will only authorise **treatment** that takes place at a **hospital** eligible on your plan, under the care of a **consultant** or therapist recognised by us. You should check your cover so you understand if there are any payments you will need to make yourself (such as an **excess**). For further information on costs you may have to pay yourself, please refer to the "Costs you might have to pay yourself" on page 25.

The **hospitals** eligible under your plan may change from time-to-time, including during a **plan year**. If you're already receiving **in-patient** or **day-patient treatment** in a **hospital** that was available to you when that **treatment**, you will be able to complete your course of **treatment** at the same **hospital**.

Private Healthcare Information Network

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

Paying for treatment

We have arrangements in place with the **hospitals** on our lists that enable them to bill us direct for eligible **treatment**. Where this is the case, we will pay the **hospital** or person who provided your **treatment** directly.

If you do receive any invoices for **treatment** covered under this plan then these should be sent to us within six months of your **treatment** to be eligible for payment, unless there is a good reason why you can't do this.

If you have already paid for your **treatment**, then you will need to provide us with an itemised receipted invoice and we will then reimburse you for any eligible costs, once the **treatment** has taken place. If you do not obtain authorisation from us for your **treatment** before it takes place, we will only pay you the amount we would have paid the provider directly had we authorised the claim in advance (pre-authorisation is not required for claims under the Optical, Dental and Hearing Cover option).

If you do not submit your invoices within six months of the **treatment** taking place, we will be unable to reimburse you for your **treatment**. You must also submit any claims for NHS hospital cash benefit within six months of the **treatment** taking place, and any claims for Childbirth cash benefit within six months of the birth or adoption.

If you die after paying for your **treatment** but before reimbursement

to you, we will reimburse the executors of your estate.

Any money paid to or by us will be in pounds sterling.

We will not add interest to any money paid under the plan.

If you're covered by another plan

If you have any other current plan that covers the same costs as we do, you must provide us with full details of the other plan, including insurer name and address, plan and claim number and any other relevant information when you first submit your claim. We will then contact the other insurance company to ensure that we only pay our proportion of the claim; this may involve us sending your personal information regarding your claim to the other insurer.

If somebody else has caused you to claim

If you, or an **insured dependant**, are claiming under this plan for eligible **treatment** for an illness or injury caused by somebody else (a 'third party'), you must tell us as soon as possible and supply us with all the relevant details of that third party.

If you are then pursuing a personal claim for damages against the third party, you must provide us with the full name and address of the solicitor handling the action. We will then contact the solicitor to register our interest and seek to recover our own costs, plus interest, in addition to any damages that you may recover or be awarded.

If we choose, we also have the right in your name but at our expense to:

- take over the defence or settlement of any claim
- start legal action to claim compensation from a negligent third party
- start legal action to recover from any third party payments that have already been made.

If you, or an **insured dependant**, are able to recover from the third party (whether or not through legal action) compensation that includes any **treatment** costs we've paid, you must repay that amount to us. Any interest that you may also have been awarded that relates to the recovered **treatment** costs is also payable to us. If you only receive a proportion of your claim for damages then you should repay to us the same proportion of our costs.

Any costs we recover will not be taken into account when calculating your renewal premium

If we pay treatment costs outside the terms of your cover

If we agree to pay **treatment** costs that aren't eligible under the terms of your cover with us, then any payments we make will still be subject to any **excess** or cover limits that apply, and they will be included in the claims amount when calculating your renewal premium for the following year. The fact that we've made these payments once does not mean we will make them again in the same or similar circumstances.

Conditions of your plan

This section deals with the general conditions of having a plan with us. There are other conditions that specifically relate to the process of having your **treatment** authorised, and these are outlined in the "How to arrange treatment" on pages 32 and 33.

What we expect from you (the planholder)

You must:

- ensure all premiums are paid when due, in accordance with the invoice we send you. You can choose to pay your premium annually, quarterly or monthly. If you pay annually, then your premium will correspond to one year's cover. If you pay quarterly or monthly then each premium will correspond to three months' or one months' cover, respectively.
- inform us of your new address if you move house, or if you or any **insured dependants**' personal details change (this includes telephone numbers and email addresses). You can update all of these details on the Member Zone.
- inform us if you or any **insured dependants** are no longer resident in the **UK**
- inform us if you or any **insured dependant** become employed in, or leave employment from any of the following occupations:
  - **professional sports** and semi-professional sports
  - working offshore in the extraction/refinery of natural/fossil fuels
  - armed forces (including the Armed Forces Reservists).

When you first start your plan, and in advance of each **annual renewal date**, we will send you a new membership certificate. The membership certificate will detail:

- any **insured dependants** we have agreed to cover
- details of the cover options you have, and any limits that apply
- your acceptance terms, including any personal medical exclusions

You should read your membership certificate alongside these terms and conditions. It is your responsibility to check that the details are accurate and to let us know immediately if anything needs to be corrected.

What you (the planholder) can expect from the plan and from us

Your entitlement to benefit will end after the last day of the period covered by your final premium payment. In such circumstances, we will only be liable for the cost of eligible **treatment** that takes place before that date. Once your cover under this plan ends, no further benefit will be payable for any **treatment** received after that date by you or any of your **insured dependants**.

This will be the case even if:

- a claim started before your cover ended, or
- you or any of your **insured dependants** are in the middle of **treatment**, or
- we have authorised **treatment** that is due to take place after your cover has ended, or
- you have notified us of further **treatment** that is due to take place after your cover has ended.

Providing premium payments are maintained, this plan will last for one year at a time. We have the right to alter the terms of your plan at each **annual renewal date**, including premium rates and cover. Before each **annual renewal date** we will tell you the premium rates and plan terms that will apply for the next **plan year**. We will also tell you of any changes to your cover and the plan terms for the next **plan year**. We will always give you reasonable notice of any changes to your plan terms. We will automatically renew your plan at each **annual renewal date** on the basis notified to you, unless you tell us not to. If you have included Worldwide Travel Cover on your plan, you can ask us not to renew this element of your cover automatically. If you opt out of renewing this element of your cover automatically, and we do not receive confirmation from you that you wish to renew your Worldwide Travel Cover prior to your **annual renewal date**, then the rest of the plan will renew automatically, and your Worldwide Travel Cover will end at your **annual renewal date**.

We may end the plan named on your membership certificate. If we do, we will offer to transfer you to another plan with similar benefits if one is available.

Some changes can occur during the course of the **plan year**, including:

- your plan premium, if you move house, add dependants to your plan, or remove dependants from cover
- the **hospitals** eligible under your plan
- changes to the **Healthy Living Programme** (for more information relating to the **Healthy Living Programme** please refer to "How the Healthy Living Programme can change" section on page 38)
- changes required for legal, regulatory or tax reasons

In specific circumstances, we also reserve the right to cancel your plan during the course of the **plan year**. These circumstances are detailed in the "Cancelling your plan" section on page 37.

You may only apply to change the level of cover at the **annual renewal date**. Any increase in cover or change to your **excess** may be subject to new acceptance terms. In some circumstances, you may not be able to make changes to your plan (e.g. you already have **treatment** planned at the

time, or you are about to start a claim).

We will tell you about any changes to the cover or general procedures using your preferred contact details. Even if you do not receive this, the change will still stand. In addition, any changes to your cover we have issued previously will remain in force at each **annual renewal date** unless otherwise stated. In the unlikely event that you do not receive your renewal invitation at least one month before the end of the **plan year** you should contact us or your adviser.

Dishonesty and Fraud

We believe our customers are honest, and the contract between us is based on mutual trust. Representations including statements and information provided by you or any **insured dependants** are relied on in assessing the terms of cover. In the event that any of the information provided by you or any **insured dependant** is wrong or incomplete we may have the right to cancel cover with effect from your **cover start date** and/or to decline claims made under the plan.

If any claim is in any respect dishonest or fraudulent or if any dishonest or fraudulent means or devices are used by you, any member of your household or anyone acting on your or their behalf to obtain benefit under your plan (including any benefits under the **Healthy Living Programme**), then all benefits under your plan may be lost and you may have to return to us any payments already made as a result of any dishonest or fraudulent actions.

VitalityHealth is involved in a number of initiatives to detect and prevent insurance fraud. If fraud is suspected, we may exchange information about you with other insurance companies, fraud prevention agencies and the Police.

Payments and currency

All payments we make to you will be in pounds sterling (GBP), to a bank account registered in the **UK**. All payments made to us must also be in pounds sterling, from a bank account registered in the **UK**. We would normally expect you (the **planholder**) to be the registered holder of the bank account, but it can also be in the name of your employer, or a person with whom you have a close personal relationship, such as a family member or close friend. We may make additional checks to establish your relationship with the account holder, and to ensure you have their agreement to make and receive payments. Please contact us if you are unsure whether the bank account is eligible.

International sanctions

We will not provide cover, pay a claim or provide any benefit or payment under the plan if, by doing so, we would be exposed to any sanction, prohibition or restriction issued by, amongst others

- The United Nations
- The **UK** Government
- The European Union

If we discover that you or any **insured dependant**, or any person paying for (or benefiting from) the plan, is subject to international sanctions, either directly or indirectly, we will immediately stop providing cover and end all benefits and payments under the plan, without any refund of premiums.

If you are, or become, aware that you or any **insured dependant** are subject to such sanctions, you must let us know immediately.

Once sanctions against you are lifted, we may be able to reinstate your plan, or you may reapply for cover under a new plan. If you decide not to continue a plan with us, any premiums that were paid, for cover after the date on which we stopped providing benefit, will be returned to you.

The law applicable to this plan

Your plan is bound by English law and comes under the jurisdiction of the **UK** courts. The language used in these terms and conditions and any communications relating to them will be in English. The contents page and any headings are for convenience only and do not form part of the plan itself and nor do they affect its construction.

Our liability under this plan

Our liability under this plan is limited to paying for **treatment** or services in respect of eligible claims under this plan. The choice of provider of the **treatment** or services ("provider") for which you are claiming under this plan is your responsibility, except:

- if you are covered under our Consultant Select option, in which case your **treatment** will be provided by a **hospital**, **consultant** or therapist on our panel
- for Weight loss surgery or Corrective surgery benefits which must be arranged through a consultant group nominated by us.

We make no representations or recommendations to you or any of your **insured dependants** regarding the availability and standard of any **treatment** or services offered or provided by any provider.

We will not be held liable to you or any **insured dependant** for any loss, harm or damage of any description resulting from lack of availability or from a defect in the quality of any **treatment** or service offered or provided by such provider. This plan represents the whole and only agreement between you (the **planholder**) and VitalityHealth relating to the provision of private medical insurance.

We use partners to offer services and activities related to the **Healthy Living Programme**. While these companies are carefully selected, we cannot be held liable for any loss or harm to you or any **insured dependants** arising from any act or omission on the part of a partner, or as a result of using any service or product provided by a partner.

Events outside our control

We will not be liable for any delay or failure to perform our obligations under this plan if it is caused by circumstances beyond our reasonable control. Examples include:

- riot or civil commotion
- changes to the law or instructions from the regulator
- a fire, flood or storm

Other conditions

We do not accept proof of posting an application form, claim form or premium payment as proof that we have received it.

You cannot be insured on more than one Personal Healthcare plan at the same time.

Cancelling your plan

You may choose to cancel your plan at any **annual renewal date**. You also have the right to cancel your plan during the **plan year** subject to certain conditions. These are detailed below, along with the circumstances in which we may cancel your plan.

Cancelling the plan in the first 14 days

You may cancel your plan from the **plan start date** providing you tell us within the first 14 days of cover, or within 14 days from when you receive your terms and conditions, whichever is the later. The same cancellation rights also apply at each **annual renewal date** of your plan. We will refund all premiums you have paid, providing you've not already made a claim. However, you will not receive a refund for any partner activities used or points earned. Cancellation rights for any gym membership will depend on the terms and conditions of the relevant gym.

If you make a claim for which we pay invoices, you will need to pay this back to us. If the value of the claim is lower than the premium you have paid to us, we will deduct it from the premium amount we return to you.

Cancelling your plan after the first 14 days

If for any reason you decide to cancel your plan after the 14 day period, please let us know either by telephoning, emailing or writing to the customer services team that administers your plan.

We will refund any premiums you have paid that relate to the period after your cancellation date, providing you've not already made a claim. Please note that we will not backdate cancellation or pay for any **treatment** that takes place after your last day of cover, you will not receive a refund for any partner activities used or points earned, and cancellation rights for any gym membership will depend on the terms and conditions of the relevant gym.

If you make a claim for which we pay invoices, then you will be charged a pro-rata premium, or the amount we have paid in claims, whichever is the greater. However, the charge will not be more than the full annual premium.

In addition, if you cancel your plan prior to the end of the 12 month term your plan covers, we reserve the right to charge an administration fee of £40.

Our right to cancel your plan

We can cancel, refuse to renew or change the terms of your plan, or withhold any benefit under the plan, at any time if any of the following happen:

- you have given us incomplete or untruthful answers in any information we've asked you for, whether this was deliberate, reckless or negligent
- you commit a breach of the terms of your plan. A breach will include, among other things:
  - the non-payment of premiums when they are due. We may, at our discretion, reinstate cover if any outstanding premiums are paid within seven days of our telling you that we have cancelled your plan due to non-payment
  - attempting to claim benefit that you know you are not entitled to claim
- you and/or any **insured dependants** cease to be residents of the **UK**
- our relationship with you has, in our judgement, irreparably broken down. Circumstances include, but are not limited to:
  - being abusive to our members of staff,
  - issuing court proceedings entirely without merit
  - any action which leads us to believe you will not act in good faith in your dealings with us.

If we cancel your plan, we will contact you, using your preferred method of communication, giving you 14 days notice. This does not apply to cases where you have attempted to claim benefits you are not entitled to (fraud), in which case we will cancel the plan immediately.

Where we cancel the plan for any of the reasons listed in this section, you will not be entitled to a refund of any premiums relating to a period prior to the cancellation date.

Where we change the terms of your plan, we will advise you as soon as we can of the reasons for any such change.

How the Healthy Living Programme can change

- The **Healthy Living Programme** will naturally change over time as new opportunities and technologies arise. It is also dependent on our relationship with third party providers and the range of services they offer.
- We may change the way we award points and/or the eligible partner activities and the Vitality status you may achieve as a result. We may also change our Vitality partners from time to time and the incentives we offer. There may be instances where other aspects such as particular benefits, may be significantly enhanced, changed or withdrawn.
- These changes may occur if our Vitality partners offer additional services or become unable to maintain their levels of service to us, or where we add new Vitality partners. Changes may also be required to prevent the fraudulent use of benefits. Revisions may be required as a result of other factors beyond our control.
- Benefits can be expressed as a straightforward Pound amount, a percentage discount off a provider's standard price, a percentage cashback on the provider's standard price or as a benefit without a specific retail value. We reserve the right to increase a straightforward Pound amount of a particular benefit during the **programme year**. If we do need to increase these prices, we will increase them for all our members at the same time, to avoid any confusion. Any price increases will only occur once during a **programme year**. No price increase shall exceed the amount equal to the change in the Consumer Price Index (since our last price increase for that benefit) as calculated against the Bronze price (or the price paid by all members if there is no difference in price according to Vitality status). For example, if the Bronze price (or standard price, if applicable) for a particular benefit is £100, and the CPI increases 3%, the maximum price increase for any Vitality status shall be £3. Therefore, if the Platinum price for that particular benefit is £10, the most someone on Platinum status would pay is £13.
- The cost of benefits expressed as a percentage discount off a provider's standard price, or as a percentage cashback on the provider's standard price, may vary during a **programme year** if that provider changes its standard price. For example, if the current standard price of a benefit is £40, and the current discount for that benefit is 50%, the cost to you would be £20. If the standard price was increased to £50, the cost to you would be £25.
- We will usually tell you about any changes including any price increases, at least six weeks before the changes take effect, unless we're unable to do so due to factors outside our control. If you're not satisfied with the changes, you may cancel your plan in line with the cancellation provisions of your plan. For this VitalityHealth plan, the "Cancelling your plan" on page 37. However, please note that you may still be subject to the notice period of any relevant Vitality partner and to any other relevant terms and conditions of that Vitality partner.
- Please note that the previous clause refers just to changes made within the **programme year** and does not prevent us from applying changes and price increases at the start of each new **programme year**.
- New adult dependants or partners who join during a **programme year** may alter the Vitality status thresholds but can immediately participate in partner activities and earn Vitality points.
- Anyone leaving Vitality before the end of the **programme year** will not be entitled to any share of benefits they may have earned during that **programme year**. All of a **planholder's** and **insured dependant's** benefits will cease when their cover ends subject to the notice period of any relevant Vitality partner. Also, all Vitality points they've earned will be removed from the plan and Vitality status thresholds will be adjusted accordingly. Your Vitality status may immediately go up as a result of such a change, but will not go down during that **programme year**.
- There will be no refund/reward in respect of any partner activities or Vitality points earned once a plan has been cancelled.
- We will not be able to backdate the award of Vitality points in respect of a **programme year** more than three months after the end of that **programme year**.
- Unless we tell you otherwise, the limits associated with the discounts and rewards we offer as part of the **Healthy Living Programme** will not be multiplied by the number of plans you hold with the Vitality Group. For example, if you hold an insurance plan with VitalityHealth, and another insurance plan with VitalityLife, both of which offer the same benefit under the **Healthy Living Programme**, you will not get double the benefit allowance. Not all plans offered by the Vitality Group, that include the **Healthy Living Programme**, have the same discounts, cashback and rewards associated with them. Where you have more than one plan with us that includes the **Healthy Living Programme**, your discounts, cashback and rewards will be based on the plan that, in our view, gives you the most comprehensive package of benefits. If you also have a VitalityCar plan, you will receive rewards as part of the Good Driving Programme, in addition to those you receive under the **Healthy Living Programme**.

How your premium can change

We believe that premium changes should be fair, intuitive and transparent so, in this section, we have outlined how we calculate the changes to your premium at each **annual renewal date**. We call this our ABC pricing approach.

We take the following into account when determining your renewal premium:

- your Age. As it is more likely you will need to claim as you get older, your premium will rise each year to take account of this.
- the Base rate. This is the change in the cost of providing healthcare, taking into account the charges made by **hospitals** and other providers, as well as advances in areas such as medical technology and drugs.
- an adjustment for the Claims you have made, and your Vitality status. This is the part of your renewal price that you can control.

The increase in your renewal premium will be the sum of these three items (A + B + C)

Examples

For examples of how your premium can change, please refer to "How your plan works in practice" on pages 48 to 51.

Your claims and Vitality status renewal table

Before the start of each **plan year**, we will show on your membership certificate how your claims and Vitality status will affect your renewal premium at the next **annual renewal date**. Please refer to your membership certificate to see how your premium will be affected at your next **annual renewal date**.

When are renewal premiums calculated?

We will calculate your renewal premium two months prior to your **annual renewal date.**

By how much will the premium rise due to age?

Typically this will be around 3%, but can be higher or lower than this depending on your age. If your children are insured on your plan, there will be a higher increase at the renewal following their 21st birthday, as they will be charged at an adult rate.

How much will the base rate rise by?

The base rate takes into account medical inflation, which tends to be higher than overall inflation, as measured by the Consumer Price Index (CPI). This is due to advances in medical **treatment** that mean more conditions can be treated than ever before. The base rate can also vary according to where you live and your level of cover, as costs can rise more sharply for certain **treatments** and in certain parts of the country.

How claims can affect your premium

In your first **plan year** we will calculate the total amount we have paid in claims for you during your first ten months on cover. In each subsequent **plan year**, we will calculate the total we have paid in claims for you in the last two months of the previous **plan year**, and the first ten months of the current **plan year**.

Based on the amount paid, you will be placed into a claims band. The level of claims that determine each band will depend on the number of adult members aged 18 or over on your plan, and is shown on your membership certificate. The lower your claims band, the lower your increase will be.

Claims paid under the following benefits will not be included:

- Primary Care benefit, including consultations with a **Vitality GP** or private **GP** on our provider panel
- Prescription charges or minor **diagnostic tests** ordered by a **Vitality GP** or private **GP** on our provider panel
- NHS Hospital Cash Benefit (including the NHS Cash Benefit for **cancer treatment**)
- Childbirth Cash Benefit
- Optical, Dental and Hearing Cover (if you have this benefit)
- Worldwide Travel Cover (if you have this benefit)

Please note that we will not allow invoices we have paid to be paid back in order to achieve a lower claims band.

How Vitality status can affect your premium

Regardless of which claims band you fall into, increasing your Vitality status can reduce the increase to your premium. The higher your status, the larger the reduction is likely to be. If you make no claims at all, you could receive a discount on your premium, before your age and base rate increases are applied.

The Vitality status we use is the one you have achieved at the end of your tenth month of cover in each **plan year** – which could be the status you carried over from the end of your last **programme year**.

You must ensure that you notify us of any points-earning activity you have undertaken, and uploaded any exercise data, before 10 months of your **plan year** have elapsed, so that we calculate your renewal premium based on the correct Vitality status. You can see which points have been credited by checking your Vitality points statement on the Member Zone or on the Member app.

Minimum premium

A minium premium applies to our Personal Healthcare plan, which can vary from time to time. If you move house or remove a person from cover during the **plan year** then your premium may drop below the minimum we allow. If this happens, your premium will be adjusted back up to the minimum level. This can either happen at the time of the change or at your following **annual renewal date**. If we change our minimum premium amount, we will only apply the change with effect from your following **annual renewal date**.

Any adjustment for the minimum premium that is made at your **annual renewal date** will be reflected in a change to your base rate increase.

Membership

Who can be covered under this plan?

- you (the **planholder**) providing you are aged between 18 and 79 at the **plan start date**
- your (the **planholder's**) husband, wife or partner, who lives at the same address as you and is aged between 18 and 79 at the **plan start date** or their **cover start date**
- your (the **planholder's**) children (including adopted children) who must be aged 25 or under at the **plan start date** or their **cover start date**. No age limit applies if:
  - your (the **planholder's**) child is switching to us from another insurer with continued personal medical exclusions underwriting terms, and
  - they join us at the same time as you, and
  - they are covered under your (the **planholder's**) plan with their current insurer

Our Worldwide Travel Cover is only available to you (the **planholder**) and your **insured dependants** providing everyone is aged 64 or under when this option is included.

You and your **insured dependants** must live in the **UK** for at least 180 days in each **plan year** and have been resident in the **UK** and registered with a **UK GP** for a minimum of six months prior to the **cover start date**. Ensuring that your **UK GP** and Dentist have your full medical/ dental records will help avoid delays in getting an eligible claim authorised by us.

If any person applying to join this plan already has cover with another insurer, we recommend they do not cancel that cover until we have confirmed that we have accepted their application by issuing a membership certificate.

How to add dependants to the plan

Your (the **planholder's**) husband, wife or partner and dependent children may apply to join at any time during a **plan year** by completing the relevant form.

If we accept them, we will issue you with a revised membership certificate to confirm their **cover start date** and any special terms (including any personal medical exclusions) that may apply.

If you (the **planholder**) add a newborn child to the plan as an **insured dependant** we will add them from their date of birth, and we will not apply the exclusion for pre-existing medical conditions or require them to be **medically underwritten**. They will be accepted on medical history disregarded terms, as outlined in the "Acceptance terms" on pages 30 and 31, providing:

- the parent has been an insured person for at least 10 months* before the birth, and
- we receive the relevant application form within three months of the birth

* this can include cover with your previous insurer if your underwriting terms are continued personal medical exclusions (switch)

There is no upper age limit for dependent children to remain on the plan, however if they are aged 21 or over they will be charged an adult rate. If they are aged 21 or over when they first join, the adult rate will apply immediately. Otherwise, it will apply from the **annual renewal date** following their 21st birthday.

If you become separated or divorced

If you (the **planholder**) have your husband, wife or partner covered on your plan and you become separated or divorced, then they will no longer be eligible to be included as an **insured dependant** on this plan. You must inform us in writing that you have become separated or divorced.

If you die

If you (the **planholder**) should die, cover for any **insured dependants** will automatically end at midnight on the date of your death. If you have paid any premiums that relate to the period after the cancellation date, then these will be refunded to the executors of your estate.

How dependants can continue their cover

If you become divorced or separated, then your husband, wife or partner may be able to continue their cover with us under their own individual plan. If you die, then your husband, wife or partner, may be able to continue cover for themselves and your insured children.

To do so, they must apply within 30 days of your separation, or within 30 days of the date we were first informed of your death. Providing your **insured dependants** continue to meet the eligibility rules of the plan, we will advise them of the premium to continue with the same acceptance terms that applied under this plan. They must start the new plan on the same date that they leave this plan. It should be noted that the benefits, terms and conditions of the new plan may be different from those of this plan.

If we are not contacted within 30 days of the date we were first informed about the divorce/separation or death, they will have to apply for a new plan with new acceptance terms. We won't backdate these applications so there may be a break in cover, and some conditions that were covered under this plan may no longer be covered. In some circumstances, we may not be able to offer cover under a new plan.

How to complain

Our commitment to you

We understand that sometimes things can go wrong. You are important to us, so if you have reason to complain we want to know. We will try to resolve your complaint quickly in a professional and helpful way.

How to contact us

You can contact us by letter, phone or email. It will help if you give your name, address and plan number. Either send us a secure message via our Member Zone at vitality.co.uk/member or call us on the number shown on your membership certificate.

Or you can write to us at:
VitalityHealth
Sheffield
S95 1DB

How we will deal with your complaint

The time it takes to resolve your complaint will depend on how complex it is and how much investigation we have to do. We will always try to resolve your complaint as quickly as possible, keeping you informed of our progress.

We will:

- Acknowledge your complaint promptly.
- Tell you who is dealing with your complaint so contacting us is easier. This person will be a trained complaint handler not directly involved with your case before the complaint.
- Fully investigate your complaint and do what we can to put things right. We will confirm the outcome of your complaint in writing.
- As part of the resolution we will clearly explain the reasons behind our decision and will action anything that needs addressing, where appropriate.
- Update you every four weeks if the investigation is not complete and explain the reason for the delay.

What to do if you are still not happy with the outcome

We want to resolve complaints to your satisfaction whenever possible. If we cannot reach agreement with you, you may have the right to refer your complaint to the Financial Ombudsman Service.

The Financial Ombudsman Service is an impartial adjudicator and provides a free, independent service for resolving disputes with financial services firms.

If you are going to ask the Financial Ombudsman to review your case, you should do so within six months of our giving you our final decision on your complaint.

You can contact the Financial Ombudsman in the following ways:

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR

Enquiry line:

0800 023 4567

Website:

www.financial-ombudsman.org.uk

Email:

complaint.info@financial-ombudsman.org.uk.

If you contact the Financial Ombudsman Service, this does not affect your right to take legal action if you are dissatisfied with and do not accept the outcome of the review.

Important privacy and regulatory information

Your rights under the Financial Services Compensation Scheme

VitalityHealth is covered by the Financial Services Compensation Scheme. If we are unable to pay your claim because we have become insolvent or are no longer in business, you may be entitled to compensation.

More details about the Financial Services Compensation Scheme, including who is eligible, can be found on their website: www.fscs.org.uk

VitalityHealth Privacy Notice

Why should you read this notice?

We think it is important for all of our members to be made aware of what information Vitality holds about them and to have the reassurance of knowing that we comply with data protection legislations. The following is a summary of our Privacy Notice. For details of the full Privacy Notice please visit vitality. co.uk/privacy

Who Vitality are

Vitality is part of the Discovery Group of companies and is owned by Discovery Limited, a financial services firm based in South Africa.

Vitality Corporate Services Limited is an authorised intermediary of: Vitality Health Limited ("VitalityHealth"); Vitality Life Limited ("VitalityLife") ("VitalityInvest"); and Vitality Healthy Workplace Limited. Together Vitality arranges and administers products provided by VitalityHealth, VitalityLife and VitalityInvest. VitalityCar is a trading name of Vitality Corporate Services Limited.

Vitality Corporate Services Limited is the data controller for the management of interactions between us and you; Vitality Health Limited and Vitality Life Limited respectively are the data controllers for the personal data and special category data that you or your representative provide to us.

Sharing your personal data

We may need to share your personal data for legal or regulatory purposes, with your authorised representative where you have appointed an insurance or financial adviser or with other companies in order to provide our products and services.

Processing claims

In the event of a claim we may require a medical report from your **GP**. Such a report will only be requested with your consent and will be in compliance with the Access to Medical Reports Act 1988 ('AMRA'). The information requested from your **GP** will be limited to only the information relevant to your claim. You have the right to request to see the **GP's** report and to request any amendments be made by the **GP** where you consider the data to be inaccurate. The **GP** may agree to this at his/her discretion. You will be informed about the AMRA process at the time we request your consent to enable us to ask your **GP** for a report.

We may have to give some information about your plan and about your health or medical status to those involved in your **treatment** or care, (and/or your representative if you have consented to us doing this). Any such disclosure will be done confidentially unless you specifically instruct us otherwise.

If the claimant is aged 13 or over we will address any correspondence to the claimant in order to protect their right to confidentiality. The **planholder** will be informed only that a claim has been made and the value of the payment we have made; no details about the medical condition or **treatment** provided will be disclosed to them. If the claimant wishes to waive their right to confidentiality they should inform us at the time the claim is made.

If you have another insurance plan that covers the same costs that you are claiming from us, then we may also disclose your relevant personal data to that other insurer so that we can ensure we only pay our proportion of the claim.

Your information, and that of others also covered by the plan, may be disclosed to other parties (for example other insurance companies) with a view to preventing fraudulent or improper claims.

Marketing

Vitality Corporate Services Limited would like to send you information about our products and future products, which currently include health, life and car insurance, investments and general insurance. We are focused on bringing exciting new products to you and to enhance those already available by offering improved services and benefits as a Vitality member.

When you purchase a product from Vitality you will be provided with access to the Member Zone where you can manage your marketing preferences and choose your preferred method of receiving information about our products, services and the benefits at any time.

If you have any queries in respect of your data protection rights or the way your personal data is processed by Vitality, please call us on:

0207 133 8600, or write to us at:

Data Protection Officer
Vitality
70 Gracechurch Street
London
EC3V 0XL

All information about data protection and privacy can be found at vitality. co.uk/privacy

Data protection complaints

We want all of our members to be happy with the way their personal data, health data and medical information has been processed by us. If you are unhappy about the way we have managed your personal data, we would like to know about it as we are constantly striving to ensure we do the right thing and we would like to be able to put things right. You'll find the contact details for our complaints teams at: vitality.co.uk/legal/complaints

If you are still dissatisfied you have the right to contact the Information Commissioner, who regulates compliance with data protection regulation and laws at: ico.org.uk

You can also call the ICO on: 0303 123 1113 or 01625 545 745, or write to them at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Important Regulatory Information

VitalityHealth is a trading name of Vitality Health Limited and Vitality Corporate Services Limited. Vitality Health Limited, company registration number 05051253, is the insurer that underwrites this insurance plan. Vitality Corporate Services Limited, company registration number 05933141, acts as an agent of Vitality Health Limited and arranges and provides administration on insurance plans underwritten by Vitality Health Limited.

Registered office at 3 More London Riverside, London, SE1 2AQ. Registered in England and Wales.

Vitality Corporate Services Limited is authorised and regulated by the Financial Conduct Authority. Financial Services Register number: 461107. Vitality Health Limited is authorised by the Prudential Regulation Authority and is regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Financial Services Register number: 400057.

You can check our authorisation on the Financial Services Register by visiting the Financial Conduct Authority's website: register.fca.org.uk

The products we offer

Vitality Corporate Services Limited only offers insurance products from Vitality Health Limited and Vitality Life Limited. A list of the products offered is available on request. Vitality Corporate Services Limited only offers private medical insurance products underwritten by Vitality Health Limited.

Definitions

These definitions are shown in bold print throughout these terms and conditions and have the same meaning wherever they appear. If you have any difficulty understanding any part of the terms and conditions, please contact us.

ACCIDENTAL INJURY

An injury directly caused by something accidental, outside the body, violent and visible. It does not include sickness, disease or any naturally occurring or deteriorating condition.

ACUPUNCTURE

A type of alternative medicine that must be carried out by a member of the British Acupuncture Council, or the Acupuncture Association of Chartered Physiotherapists, or by a medical practitioner who holds a Certificate of Basic Competence or a Diploma of Medical Acupuncture issued by the British Medical Acupuncture Society and who is recognised by us.

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.

ACUTE FLARE-UP OF A CHRONIC CONDITION

A sudden and unexpected deterioration of a **chronic condition** that is likely to respond quickly to **treatment** that aims to restore you to your state of health immediately before suffering the acute flare-up. For example we would cover eligible surgery following a heart attack that resulted from chronic heart disease. This does not include deterioration of a **chronic condition** where this is part of the normal progress of the illness, or recurring relapses of a **chronic condition**.

ALCOHOL ABUSE

Alcohol dependence or hazardous drinking that results directly in harm to physical or mental health.

ANNUAL RENEWAL DATE

The date, 12 months after the **plan start date** and each anniversary after that date.

CANCER

A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

CHECK-UP

A consultation with, or a visit to, any medical practitioner about any medical condition or any signs and symptoms of a medical condition. This includes attendance for an enhanced screening or monitoring programme following **cancer treatment**.

CHIROPODY/PODIATRY

Diagnosis and **treatment** of disorders, diseases and deformities of the feet by a chiropodist/podiatrist. **Treatment** must be given by a practitioner who is registered with the Health and Care Professions Council (HCPC) and who is recognised by us.

CHIROPRACTIC

A type of complementary medicine that must be carried out by a member of the General Chiropractic Council and who is recognised by us.

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.

CLINICAL/COUNSELLING PSYCHOLOGIST

A clinical or counselling psychologist is a mental health professional trained in the diagnosis and psychological **treatment** of mental illness, and who uses psychological techniques, rather than medication to treat mental illness. Psychologists must be registered with the Health and Care Professions Council (HCPC) and be recognised by us.

CONSULTANT

A medical or dental practitioner recognised by us:

- whose name appears on the General Medical Council or General Dental Council specialist register and has a licence to practice in the **UK**, and
- who currently holds, or has held within the past five years, a substantive, non-locum appointment of consultant or senior lecturer status in an NHS or a Defence Medical Services hospital. Alternatively, if they do not hold a substantive NHS consultant post but can provide evidence of status and clinical experience which in the opinion of VitalityHealth is equivalent to that required for appointment to such a post and who has full practising privileges in a private hospital.

COVER START DATE

The date on which each insured person's cover starts, as shown on your membership certificate.

CRITICAL CARE

Any care given in an Intensive Care Unit, Intensive Therapy Unit, Coronary Care Unit, High Dependency Unit, Paediatric Intensive Care Unit, Neonatal Intensive Care Unit, Special Care Baby Unit or similar level of care, wherever provided, is considered critical care.

DAY-PATIENT

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

DENTAL ACCIDENT

A dental accident is a sudden unforeseen external blow to the face, teeth and jaws which occurs at an identifiable place and time and results in an injury to your teeth and gums.

DENTAL HYGIENIST

A qualified dental hygienist registered with the General Dental Council.

DENTIST

A dental practitioner who is registered with the General Dental Council in general practice.

DIAGNOSTIC TESTS

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

DIETICIAN

A registered dietician who uses the science of nutrition to help in the **treatment** of medical conditions and to promote good health and who is recognised by us.

DRUG ABUSE

The taking of any non-prescription drug, substance or solvent, or misuse of a drug prescribed by a **GP** or **consultant**.

EXCESS

The maximum amount you will have to pay towards your **treatment**. The excess can apply in one of two ways. Please refer to your membership certificate to see which one applies to you.

Excess per claim – you will pay the excess amount each time you claim for a new condition and have **treatment** covered by this plan. If **treatment** for that condition continues for more than 12 months, the excess will apply again to any further **treatment** after the anniversary of the claim.

Excess per **plan year** – you pay the excess on the first **treatment** (or **treatment**s) that you have in the **plan year**. Only one excess is payable for each insured person in each **plan year**, regardless of how many conditions you claim for.

GP (GENERAL PRACTITIONER)

A medical practitioner who is registered and licensed with the General Medical Council and whose name appears on the GP register.

HEALTHY LIVING PROGRAMME

A programme offered in conjunction with certain Vitality plans which provides ways to understand your health, help you get healthier, and reward you for doing healthy things.

HOME NURSING

Skilled nursing care provided by a qualified **nurse**. Home nursing must be supervised by an insured person's **consultant**.

HOMEOPATHY

A type of alternative medicine that must be carried out by a member of The Faculty of Homeopathy, Society of Homeopaths or Alliance of Registered Homeopaths and who is recognised by us.

HOSPITAL

Any private hospital, or private wing of an NHS hospital, that is included on your hospital list, or which we have agreed in advance you can attend.

IN-PATIENT

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

INSURED DEPENDANT

- Your (the **planholder's**) insured husband, wife or partner, aged between 18 and 79 at their **cover start date**, and who lives at the same address as you.
- Your (the **planholder's**) insured children (including adopted children), who must be aged 25 or under at their **cover start date**, unless you both joined us on a continued personal medical exclusions (switch) underwriting basis, in which case there was no upper joining age. Once accepted for cover, insured children will only be removed if requested by you (the **planholder**). Children aged 21 or over will be charged an adult rate. If they are aged 21 or over when they first join, the adult rate will apply immediately. Otherwise, it will apply from the **annual renewal date** following their 21st birthday.

MEDICALLY UNDERWRITTEN/MEDICAL UNDERWRITING

The basis on which you have applied for cover and the process we use to decide the terms on which we will accept you and your **insured dependants**, based on the medical information we receive when you make your application.

NURSE

A qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number. Any **treatment** they provide must be under the supervision of a **consultant** recognised by us.

OSTEOPATHY

A type of alternative medicine that must be carried out by a member of the General Osteopathic Council (GOsC) who is recognised by us.

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**.

PHYSIOTHERAPY

Treatment carried out by a person who is registered with the Health and Care Professions Council (HCPC) as a physiotherapist and who is recognised by us.

PLAN START DATE

The date on which the plan began, as shown on your membership certificate.

PLAN YEAR

A period of 12 months from the **plan start date** or from any **annual renewal date**.

PLANHOLDER

The person who has the contract with us as shown on the membership certificate.

PRIVATE AMBULANCE

A road vehicle built solely for use as an ambulance and run by a registered private ambulance service.

PROFESSIONAL SPORTS

Any sporting activity in which the **planholder** or **insured dependant** participates as their main paid occupation, as opposed to being an amateur or semi-professional.

PROGRAMME ANNIVERSARY

The date each year that is set when your first Vitality plan that includes the **Healthy Living Programme** begins (which could be a VitalityHealth, VitalityLife, or VitalityInvest plan providing it includes the benefit of the **Healthy Living Programme**) and will correspond to the **annual renewal date** of the plan. Your programme anniversary will remain the same for as long as you continuously hold at least one Vitality plan with the benefit of the **Healthy Living Programme**, unless you become a dependant on a plan held by another person, in which case it might change.

PROGRAMME YEAR

A period of 12 months starting on the **programme anniversary** date each year.

REHABILITATION

Medical services aimed at restoring a person's function and independence following **in-patient treatment** of a disease, illness or injury.

RELATED CONDITION

Any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury. It may also be known as 'an underlying cause' and/or a 'condition arising therefrom'.

SEMI-PROFESSIONAL SPORTS

Any sporting activity for which the **planholder** or **insured dependant** receives payment (beyond expenses) for participation, irrespective of results, but which is not their main occupation.

TREATMENT

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

UK

Great Britain and Northern Ireland, including the Channel Islands and the Isle of Man.

VITALITY GP

A medical practitioner who you contact using our dedicated advice line or Vitality GP app.

How your plan works in practice

This section provides examples of how particular benefits, terms and features of the plan work. They are divided into categories.

How your Advanced Cancer Cover works in practice

Example 1

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

*We pay for the cost of the consultations and **diagnostic tests** to establish the diagnosis. We then pay for the mastectomy and the associated reconstructive surgery, as long as this takes place within five years of any related **treatment.** We then cover the course of radiotherapy and chemotherapy in full.*

We will pay the cost of the hormone therapy in full as well as the cost of medically-necessary follow-up consultations and monitoring.

Example 2

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

*We will cover both the eligible **treatment** of new **cancers** and the **treatment** of complications of **cancer** and/or secondary **cancers**. So we would pay for the cost of Cara's mastectomy and the course of radiotherapy and chemotherapy in full. We will also cover the cost of any associated follow-up consultations where medically necessary.*

Example 3

Monica, who was previously treated for breast **cancer** under her existing plan, has a recurrence which has unfortunately spread to other parts of the body.

Her **consultant** has recommended the following **treatment** plan:

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

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

*We will cover in full all aspects of Monica's **treatment**.*

Example 4

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

As hospices don't charge for their care we make a donation of £75 for each day spent in a hospice

How the Moratorium Clause works in practice

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

Because you need continuous **treatment** for your medical condition, cover for this or any **related condition** would be permanently excluded.

*Some time after my cover has started, I go to my **GP** for a routine visit and a heart condition is diagnosed. It has obviously developed during the period before the start of my plan. Would I be covered?*

The clause only applies to any medical condition or **related condition** (or both) which you were aware existed in the five years before the start of your plan. If:

- the heart condition was first diagnosed after you joined the plan; and
- you had no previous **treatment** for any obviously **related condition**, such as high blood pressure or chest pains; and
- you were not aware of any symptoms;

benefit would be available even if it was proved that the condition existed before your plan began.

*I have a medical condition that has existed during the five years before my cover began. I experience symptoms from time to time but I don't see my **GP** about it, I just take an over the counter medicine that I buy myself. Will I be able to claim for this condition, as I have not sought medical advice or taken any prescribed medication for it?*

The moratorium excludes all conditions that you were aware of during the five years before your cover began, even if you have not needed to see a **GP** about them or taken prescribed medicine. The condition will become eligible for cover, subject to the terms and conditions of your plan, if you have not received any medical advice or **treatment** or taken any medication for that condition, or any **related condition**, for a continuous period of two years after your cover starts.

*What if I suspect that I am suffering from a condition, for example, I have a lump, but have not seen a **GP** for the condition or received any firm diagnosis? Would I be covered if a visit to my **GP** after the start of the plan revealed that surgery for that condition was necessary?*

Because you were aware of the condition during the five-year period before the start of the plan, even though you weren't quite sure what it was, it would be excluded from cover for at least the first two years of the plan.

*What if I am uncertain whether **treatment** I received before the start of my plan 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 plan, you must submit a fully completed claim form to us to gain written pre-authorisation for your claim. This way we'll 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**.

*NOTE: These questions and answers provide broad guidance to help you understand how the moratorium clause works. Obviously, each claim is dealt with and treated on its own merits. How the clause is interpreted depends entirely on the facts presented. When we receive a fully completed claim form, we will be pleased to tell you whether cover is available before you have **treatment**.*

Examples of treatment for chronic (long-term) conditions

Example 1

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

*We cover Alan's initial consultations and tests and advise him that we will cover further consultations with his **consultant** until his symptoms are well controlled.*

Two years later, Alan's chest pain recurs more severely and his **consultant** recommends that he has a heart bypass operation.

*We confirm to Alan that we will cover this operation as it will substantially relieve his symptoms and stabilise the condition. We also advise him that we will cover his post-operative **check-ups** for one year to ensure that his condition has been stabilised.*

Example 2

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

*We cover Eve's consultations and tests and agree to pay for her next **check-up**. However, we advise her that we will not be able to cover her regular **check-ups** after this because her condition is now well controlled.*

Eighteen months later, Eve has a bad asthma attack.

*Due to the severity of the asthma attack, Eve needs an emergency admission to an NHS hospital which our plans are not designed to cover. However, once her condition has stabilised, we agree to cover the cost of one follow-up consultation with her **consultant** to make sure that her symptoms are well-controlled again.*

Example 3

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

*We pay for the **treatment** of Deirdre's condition up to this point. However, we advise her that because her condition is now stabilised we will not be able to continue to cover her regular four month **check-ups**. We tell Deirdre that we will cover one more **check-up** so that she has time to make alternative arrangements. We will not cover her medication at any time.*

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

*Assuming the admission is on an emergency basis, then this will usually be to a NHS hospital which our plans are not designed to cover. However, once she has been discharged we will pay for one further **check-up** to make sure that her condition is now stable.*

Example 4

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

*As Bob's plan includes cover for alternative therapies, we pay for two weeks of **treatment** as this helps stabilise his symptoms. We also tell him that we cannot cover his regular monthly **treatments**, as these are designed just to keep the symptoms in check but that if his symptoms worsen he should contact us again.*

*If Bob's condition did deteriorate significantly and his **consultant** recommended a hip replacement, VitalityHealth would cover the cost of this. As the operation would replace the damaged hip and thereby cure Bob's problem, we would pay for all the costs relating to this operation*

Example of how your premium can change

Sarah takes out a Personal Healthcare plan with us. Her membership certificate shows the following about how her claims and Vitality status will affect her renewal premium the following year:

1 Adult on the plan	No Claims Paid	Less than £300 paid	£300 - £1,000 paid	More than £1,000 paid
2 or more adults on the plan	**No Claims Paid**	**Less than £450 paid**	**£450 - £1,500 paid**	**More than £1,500 paid**
Bronze	–1.0%	5.0%	12.5%	25.0%
Silver	–2.0%	2.5%	10.0%	20.0%
Gold	–3.0%	0.0%	7.5%	15.0%
Platinum	–4.0%	0.0%	5.0%	12.5%

Please note: this table is an example. The table that applies to you is shown on your membership certificate.

Example 1

After the first 10 months, Sarah's renewal premium for the following **plan year** is calculated. At this point, her age increase is 3% and the base rate increase is 6%. Sarah has made no claims, and has reached Silver status, and so receives a 2% discount on her premium. In total, her increase is 3% + 6% – 2% = 7%.

Example 2

At the following renewal, Sarah's renewal premium is again calculated after 10 months of the **plan year**. Her age increase is 4% and her base rate increase is 6%. Sarah has made a small claim for which we pay £200 but she has increased her Vitality status to Gold, so there is no increase or discount applied. In total, her premium increase is 4% + 6% + 0% = 10%.

Example 3

Sarah decides to renew her plan for a third year of cover. However, before the end of her second **plan year** she has a recurrence of the condition she made a claim for and requires an operation, for which we pay £5,000. This does not result in a change to her premium for her third year of cover. After 10 months of her third **plan year**, Sarah's renewal premium is once again calculated, at which time her age increase is calculated at 2% and the base rate at 8%. She has also improved her Vitality status to Platinum and made no further claims. The £5,000 we paid at the end of the previous **plan year** is now taken into account, and Sarah receives a 12.5% increase to her premium. Sarah's total increase is 2% + 8% + 12.5% = 22.5%.

Example 4

In her fourth year of cover, Sarah's renewal premium is again calculated after 10 months. Her age increase is calculated at 3% and the base rate at 7%. She has made no further claims, and she is still on Platinum status, having carried it over from the previous **plan year**. Sarah's total increase is 3% + 7% – 4% = 6%

How your excess works in practice

Example 1 – Excess per person per plan year

Elliot takes out a plan with us that starts on 1 January. He chooses to include a £250 **excess**, applied per person per **plan year**. In April of the same year, he injures himself playing football and needs to have some **physiotherapy**. As he has full Out-patient Cover, this is eligible under his plan. He has six sessions of **physiotherapy** costing £300. As this is the first **treatment** he has made a claim for in the **plan year**, we pay £50 and advise Elliot that he must pay the remaining £250, his **excess**, to the provider directly.

In August, Elliot has some stomach pains and is referred to a **consultant**, who orders an MRI scan. The results show a small hernia, and he has a procedure to have it repaired. The cost of the **treatment** comes to £3,000. As he has already paid all of his **excess** for **treatment** occurring in that **plan year**, we cover the **treatment** in full.

Example 2 – excess per claim

Jennifer takes out a plan with us that starts on 1 February. She chooses to include a £100 **excess** on her plan, applied to each claim. In May of that year, Jennifer has a skin complaint and is referred to a **consultant** dermatologist. The dermatologist orders some **diagnostic tests** and, after receiving the results, prescribes some medication. The cost of the consultation and tests comes to £500. As Jennifer has full Out-patient Cover with us, and the **treatment** is eligible under the plan, we pay £400 and advise Jennifer to pay £100, her **excess**, to the **consultant**.

In July of that year, Jennifer starts suffering back pain and is referred by a **GP** to an osteopath. She has included Therapies Cover in her plan, so the **treatment** is again eligible. She has four sessions with the osteopath, costing £300. As this is a new condition, and the excess she chose to include is applied per claim, we pay £200 and advise Jennifer to pay £100, her **excess**, to the osteopath.

In February of the following year, Jennifer's plan renews. In March, her skin complaint flares up again and she is referred back to her original **consultant**, who prescribes a different medication. The consultation costs £200. As this is **treatment** for the same condition, and the first **treatment** for that condition was less than twelve months previously, no further **excess** payment is due. We pay the £200 consultation fee.

Example 3 – how excesses and benefit limits interact

Audrey takes out a plan with us with a £250 **excess**, applied per claim. She also chooses to have a £500 per **plan**

year limit on her Out-patient Cover. Six months after taking out her plan, she badly injures her shoulder and is referred to an orthopaedic **consultant**, who orders an X-ray. The cost of the consultation and X-ray comes to £450. We pay £200, and advise Audrey to pay £250, her **excess**, to the **consultant**. All the costs were eligible under her Out-patient Cover, which is limited to £500 per **plan year**. However, as we only paid £200, Audrey still has £300 benefit limit remaining:

Out-patient Cover limit for a **plan year**:	£500
Audrey incurs **out-patient** costs of:	£450
We pay:	£200
Audrey pays:	£250
Benefit limit remaining	£300

Appendix - hazardous activities

Please see below a list of activities which are considered high risk. Injury or illness sustained during or from these activities are not covered under your plan.

- Airboarding
- Base jumping
- Black water rafting grades 4 and above
- BMX freestyle
- Bobsleighing
- Boxing (in competition)
- Bridge swinging
- Bull running
- Bunjee jumping
- Cage fighting/mixed martial arts (in competition)
- Cave diving
- Cave tubing
- Climbing of the following types/ circumstances:
  - Free soloing/deep water soloing (without safety aids)
  - Ice climbing
- Coasteering (without a guide)
- Deer stalking
- Dog sled racing
- Drag racing
- Equestrian – the following events:
  - Cross country
  - Show jumping
- Expeditions, which we define as a trip of more than three weeks, to a remote location where hospital care is not available without evacuation, and:
  - The purpose of the trip is for research and/or exploration, or
  - The purpose of the trip is an endurance challenge (whether sponsored or not), or
  - Special training is needed in advance of travelling to ensure your safety in the region
- Free diving (without breathing apparatus)
- Hang gliding (as pilot)
- Harness racing
- Hiking/trekking above 6,000m altitude
- Horse racing
- Hunting
- Ice diving
- Ice speedway
- Jousting
- Luge
- Marathons occurring partly or wholly in the Arctic or Antarctic circles
- Microlighting
- Motocross
- Motorcycle racing
- Motor paintball
- Motor racing
- Motor rallies
- Motor sport time trials
- Mountain bike racing of the following types/events:
  - Downhill mountain bike racing
  - Megavalanche (or similar)
  - Rumble in the jungle (or similar)
  - Trans savoie big alpine endure (or similar)
  - Yak attack
- Mountaineering of the following types/ circumstances:
  - Above 3,000m altitude and using ropes or climbing equipment
  - Free soloing (without safety aids)
  - Solo mountaineering
- Paramotoring
- Potholing/caving (exploratory)
- Power boat racing
- Quad bike racing or rallying
- Quad biking over 300cc
- River bugging
- Sailing/yachting more than 30 miles from the shore
- Scuba diving in the following circumstances:
  - When not in open water at all times, or
  - When using more than one breathable gas, or
  - At a depth of more than 30m, or
  - When not as part of a buddy pair or group, or
  - When not within divers certified limits or under training for new certifications
- Skeleton
- Skiing/snowboarding of the following types/circumstances:
  - Aerial skiing/snowboarding
  - Ski bob racing
  - Ski cross
  - Ski flying
  - Ski jumping
  - Ski racing (downhill)
  - Ski stunting
  - Skiing acrobatics
  - Skiiing/snowboarding against local authority's warning or advice
  - Skiing/snowboarding freestyle (including inverted aerials)
  - Skiing/snowboarding off-piste, out of resort

- Skydiving
- Speedway
- Stunt performance
- Tombstoning
- Ultramarathons – the following circumstances/events:
  - Where normal temperatures for the event are lower than 0 degrees celsius or higher than 30 degrees celsius
  - Marathon des sables
  - Kalahari augrabies ultra marathon
- White water canoeing grades 4 and above
- White water hydrospeeding grades 4 and above
- White water kayaking grades 4 and above
- White water rafting grades 4 and above
- Wingsuit flying
- World's toughest mudder

Please note that, where any of the above activities take place on a track, course, ring or arena, that illness or injury sustained while warming up for the event on that track, course, ring or arena will also be excluded.

Subject to the terms and conditions of your plan, illness or injury sustained during any activity not listed above will be covered, providing:

- you use the appropriate safety equipment for your activity and follow the standard safety procedures
- any third party arranging the activity has the appropriate permissions and licenses to do so.

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