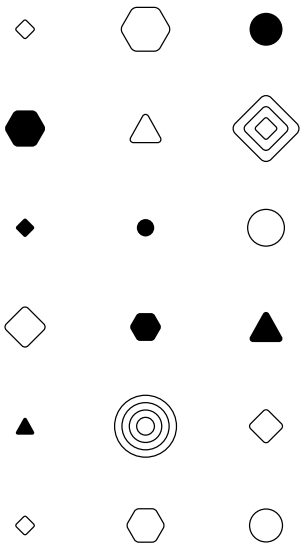
Simplyhealth

Your Simply Cash Plan

Policy document

Effective from 1st September 2018



Your table of cover

	Level 1	Level 2	Level 3	Level 4	Level 5
Monthly premium for you	£13.43	£17.51	£21.65	£27.38	£43.91
Monthly premium for you and your partner	£24.80	£29.39	£38.18	£51.66	£73.36
Cover for up to four of your children under the age of 18	FREE				

Premiums include Insurance Premium Tax where applicable

myWellbeing	Available to all levels of cover
Speak to a GP Speak to a GP over the phone 24 hours a day, 7 days a week. If the GP feels it's clinically appropriate, they may privately prescribe you some medication. They can arrange for this to be delivered to you at home or at work. You'll be charged for the cost of the medication and the cost of the delivery.	
Telephone counselling Speak to a qualified counsellor over the phone 24 hours a day, 7 days a week	
Wellbeing and lifestyle guidance Speak to someone over the phone about your wellbeing, legal and financial challenges or relationship issues 24 hours a day, 7 days a week	

We also have a range of health-related information and services which can be accessed through your online account

To help keep your eyes and teeth healthy	We pay	Annual limit for each person				
Dental Includes check-ups and treatment, for example fillings, crowns and bridges, hygienist's fees, dentures	100% of your receipt up to your annual limit	£100	£120	£160	£190	£280
Dental accident (3 month qualifying period) Treatment to help return your oral heath to its pre-accident state		£100	£250	£500	£750	£1000
Optical Includes sight tests, prescription glasses and contact lenses		£100	£120	£160	£190	£280
To help you feel your best	**We pay**	**Annual limit for each person**				
Physiotherapy, osteopathy, chiropractic, acupuncture You can use your annual limit for one or all of these treatments	50% of your receipt up to your annual limit	£295	£345	£420	£520	£770
Chiropody / podiatry, homeopathy and reflexology Includes treatment and assessments, for example gait analysis, by a chiropodist or podiatrist as well as homeopathy and reflexology		£100	£125	£150	£200	£300
To help you find out what's wrong	**We pay**	**Annual limit for each person**				

Diagnostic consultation Consultant's fees for a diagnostic consultation that is to find or help to find the cause of your symptoms. Includes allergy testing	**50%** of your receipt up to your annual limit	**£175**	**£200**	**£260**	**£320**	**£525**
X-rays and scans Consultant referred X-rays and scans (this does not include CT, MRI or PET scans)		**£75**	**£90**	**£110**	**£250**	**£370**
To help you find out more about your health	**We pay**	**Annual limit for each person**				
Health assessment Helps towards the costs of a detailed assessment of your health with a nurse, doctor or pharmacist. The benefit is not available to children	**50%** of your receipt up to your annual limit	**£100**	**£125**	**£150**	**£200**	**£300**
To help you when you need it most	**We pay**	**Annual limit for each person**				
Hospital Cash amount when you are admitted to hospital, or staying overnight with your child. Pre-existing conditions are excluded for the first 12 months	For each day / night (max 20 each year)	**Adult £28** **Child £14**	**Adult £35** **Child £18**	**Adult £40** **Child £20**	**Adult £60** **Child £30**	**Adult £90** **Child £45**
Medical apparel (maximum two items each policy year) Helps towards the costs of items that you need to wear for medical reasons	**50%** of your receipt up to your annual limit	**£250**	**£300**	**£400**	**£500**	**£750**
Prescriptions charges Prescriptions issued by a GP or Dentist	**100%** of your receipt up to your annual limit	**£8.60**	**£17.20**	**£25.80**	**£34.40**	**£43.00**
Redundancy premium protection (12 month qualifying period) We will cover the premiums for a maximum of six months in the event the policyholder is made redundant and subsequently unemployed		✓	✓	✓	✓	✓
To help you when your family grows						
New child payment (12 month qualifying period) One payment for each child if you or your partner have a baby or adopt		**£175**	**£200**	**£250**	**£325**	**£450**

Weekly premium for you	**£3.10**	**£4.05**	**£5.00**	**£6.32**	**£10.14**
Weekly premium for you and your partner	**£5.72**	**£6.80**	**£8.82**	**£11.92**	**£16.94**

The joining age for this policy is from 18 years old up to 79. If anyone on the policy is aged 80 or over, you will not be able to increase the level of cover.

You can find full policy details in the policy documents.

Introduction

Thank you for buying a Simplyhealth cash plan. This document explains the policy rules, and how the policy works. These rules apply to all members of the policy.

Please take the time to read them and keep them safe in case you need them again. If you have any questions, then please contact us.

We aim to make information about us and this policy accessible to you, whatever your needs, and information is available in large print or audio.

We want you to have a policy that meets your needs, and this product you have chosen meets the needs of someone who would benefit from support with the costs of their healthcare appointments. Please remember to review your cover on a regular basis to make sure that it continues to meet your needs.

How does my cash plan work?

It's simple: we'll pay your eligible claims up to the amounts shown for your level of cover for each benefit, every **policy year**. Your summary of cover will show which level applies to you.

For some of your benefits, we'll pay you a percentage of the costs you've paid for your treatment or service. For example, if your payback level is 75% and you've paid £100, we'll give you £75 back. Your **table of cover** shows the percentage of your costs that we'll pay back.

Section 1: How to make a claim

How do I make a claim?
The first thing you need to do is pay for the costs of the treatment or service to the person providing them (for example, your optician). You then claim those costs back from us.

It's really easy to claim online. Please visit simplyhealth.co.uk/register and follow the simple registration process.

If you're unsure about how to claim online then please contact us.

What do I need to provide so my claim can be paid?
Before we're able to pay your claim, we need to be sure that the policy covers it. For example, we need to be sure that the person who receives the treatment or service is a **member**, and that there is not an exclusion that applies.

You'll need to send us evidence (for example your receipts) that shows:

- who the patient is
- who gave the treatment or service and how much they've charged
- the details and date of the treatment or service and
- the amount that you've paid.

We won't be able to pay a claim if you don't send us everything that we need to assess it.

We don't accept receipts that have been altered, bank statements, invoices or credit or debit card receipts without supporting evidence. We are unable to return receipts.

What happens if more information is needed to assess my claim?
We may need to ask the person who provided the service or treatment for more details. We won't pay if there's a charge for this.

We may ask for a second opinion but we'll pay the cost for this.

Section 2: Your cover

This section explains what is and isn't covered for each of the benefits on this **policy**. You decide the treatments and services that you need, and the people who provide them. We aren't responsible for the treatment or services you receive or for any consequences that may result from them.

myWellbeing

We have a range of services and health-related information available to you. You can access these services through your online account. If you haven't already registered please visit simplyhealth.co.uk/register and follow our simple registration process. The information and services available on the myWellbeing website can change without notice from time to time.

Some of the myWellbeing services are only available in the UK. The website will tell you which of the services this applies to.

Speak to a GP
The service is available 24 hours a day, 365 days a year by calling 0330 102 5443. eConsultations are also available from 8am to 10pm, Monday to Friday, 8am to 8pm on Saturday and 10am to 6pm on Sunday.

If the GP feels it's clinically appropriate, they may privately prescribe you some medication and they can arrange for it to be delivered to you at home or at work. Next day delivery is available where the

request is received by the pharmacy before 3pm, Monday to Friday and the items are available. You will be charged for the cost of the medication and the cost of the delivery.

If the **table of cover** shows cover for **children**, the **child's** parent or legal guardian will need to call the service on their behalf.

Telephone counselling
The service is available 24 hours a day, 7 days a week by calling 0330 102 5445.

This service is not available to anyone aged 16 or under. Please see the myWellbeing website for more information.

Wellbeing and lifestyle guidance
This service is available 24 hours a day, 7 days a week by calling 0330 102 5445.

This service is not available to anyone aged 16 or under. Please see the myWellbeing website for more information.

Dental

This benefit is to help towards the costs when you see a qualified dental professional (for example a dentist or hygienist) in a dental surgery.

What the dental benefit covers
- ✓ dental check-ups
- ✓ treatment provided by a dentist, periodontist or orthodontist
- ✓ endodontic (root canal) treatment
- ✓ hygienists' fees
- ✓ local anaesthetic fees and intravenous sedation
- ✓ dental brace or gum-shield provided by a dentist or orthodontist
- ✓ dental crowns, bridges and fillings
- ✓ dentures
- ✓ laboratory fees and dental technician fees referred by a dentist or orthodontist
- ✓ dental X-rays
- ✓ denture repairs or replacements by a dental technician.

What the dental benefit does not cover
- × dental prescription charges
- × dental consumables, for example toothbrushes, mouthwash and dental floss
- × dental implants and bone augmentation procedures, for example sinus lift, bone graft
- × cosmetic procedures, for example dental veneers, tooth whitening, the replacement of silver coloured fillings with white fillings
- × laboratory fees not connected to dental treatment or performed by a dentist
- × dental treatment provided at a hospital as a day-patient or in-patient
- × **general exclusions**.

Dental accident

This benefit is to help towards the costs of returning your oral heath to its pre-accident state following an accident. An accident is an incident that happens by chance, which could not have been expected, causes a significant dental injury and requires medical or dental attention.

This benefit has a **qualifying period** of three months.

In order for us to assess your claim, we'll need evidence that an accident has taken place and that the treatment you've received is clinically necessary and as a direct result of the accident. You must send us a copy of your dental or medical records (which should include any relevant X-rays) confirming this.

We will ask for additional evidence, such as witness statements, photographs and police incident numbers if your records do not provide the information we need to assess your claim.

What the dental accident benefit covers
- ✓ restorative treatment to return your oral health to its pre-accident state if you receive medical or dental attention within 30 days of the accident
- ✓ the standard NHS rate for one prescription (whether the prescription is an NHS or private prescription). The prescription must be written by a dentist or doctor**.** This does not cover Prescription Prepayment Certificates (PPC) or any medicine obtained using one.

What the dental accident benefit does not cover
- × dental treatment that you need as a direct result of an accident that occurred before you joined the **policy** or within the **qualifying period**
- × further dental treatment that you need after the immediate restoration of the accident damaged area, for example remedial improvements to, or the modification of, work carried out as a result of the accident
- × dental treatment that you need as a result of participating in a sport that has a higher than average likelihood of dental injury and where it is reasonable to expect you to wear face or mouth protection, for example hockey or rugby, and where you were not wearing the appropriate face or mouth protection
- × dental treatment that you need as a result of injury caused by foreign bodies or foodstuffs while eating, chewing or drinking

- × any dental treatment undertaken in a hospital following a referral from a dentist
- × dental treatment that you cannot provide evidence of being clinically necessary, for example cosmetic procedures
- × any preparation for and treatment connected with having implants or veneers fitted. This exclusion does not apply to an existing veneer which is damaged in an accident covered by the **policy**, or for an existing implant abutment, crown or bridge which is damaged in an accident covered by the **policy**
- × claims relating to treatment arising directly or indirectly from:
  - you participating in a criminal act
  - an accident while you were under the influence of alcohol or drugs
  - deliberate self-inflicted injury
- × dental treatment that you need as a result of war or terrorist activity
- × **general exclusions**.

Optical

This benefit is to help towards the costs when you see a qualified optical professional (for example an optometrist or optician).

What the optical benefit covers

- ✓ sight-test fees, scans or photos for an eye test
- ✓ fitting fees
- ✓ prescribed lenses and accompanying frames for:
  - glasses
  - sunglasses
  - safety glasses
  - swimming goggles
- ✓ adding new prescribed lenses to existing frames
- ✓ glasses frames
- ✓ contact lenses (including contact lenses paid for by instalment)
- ✓ consumables supplied as part of an optical prescription, for example solutions and tints
- ✓ repairs to glasses.

What the optical benefit does not cover

- × eye surgery (for example laser eye surgery, lens replacement surgery or cataract surgery)
- × optical consumables, for example contact lens cases, glasses cases and glasses chains/cords, cleaning materials
- × magnifying glasses
- × eyewear that does not have prescription lenses
- × ophthalmic consultant charges or tests related to an ophthalmic consultation
- × **general exclusions**.

Physiotherapy, osteopathy, chiropractic, acupuncture (POCA)

Important: In order to be able to practise in the UK:

- Physiotherapists must be registered with the Health and Care Professions Council (HCPC)
- Osteopaths must be registered with the General Osteopathic Council (GOsC)
- Chiropractors must be registered with the General Chiropractic Council (GCC).

We will not pay for treatment by someone who is not registered with the HCPC, GOsC or GCC (as appropriate).

What the POCA benefit covers

- ✓ physiotherapy
- ✓ osteopathy
- ✓ chiropractic
- ✓ acupuncture.

What the POCA benefit does not cover

- × any other treatments, for example reflexology, aromatherapy, herbalism, sports/remedial massage, Indian head massage, reiki, Alexander technique
- × X-rays and scans
- × appliances, for example lumbar roll, back support, TENS machine
- × **general exclusions**.

Chiropody/podiatry, homeopathy and reflexology

Important: In order to be able to practise in the UK chiropodists / podiatrists must be registered with the Health and Care Professions Council (HCPC).

We will not pay for chiropody / podiatry treatment by someone who is not registered with the HCPC.

What the chiropody/podiatry, homeopathy and reflexology benefit covers

- ✓ treatment supplied by a chiropodist or podiatrist
- ✓ assessments, for example gait analysis, performed by a chiropodist or podiatrist
- ✓ consumables prescribed by and bought from the chiropodist or podiatrist at the time of treatment, for example orthoses, dressings
- ✓ consultations with a podiatric surgeon

- ✓ homeopathy and homeopathic medicines prescribed by and bought directly from a homeopath
- ✓ reflexology.

What the chiropody/podiatry, homeopathy and reflexology benefit does not cover
- × cosmetic pedicures
- × X-rays and scans
- × consumables not bought from the chiropodist or podiatrist at the time of treatment, for example corn plasters bought from a pharmacy
- × surgical footwear, for example corrective footwear
- × homeopathic medicines bought from a professional who is not a homeopath or bought from a chemist, health food shop, by mail order or over the internet
- × **general exclusions**.

Diagnostic consultation

A diagnostic consultation is to find or to help to find the cause of your symptoms.

What the diagnostic consultation benefit covers
- ✓ the fees for a diagnostic consultation that you have as a private patient. The consultation must be with a medical professional who is (or has been) a consultant in an NHS hospital or the Armed Services. The consultant post must be a substantive appointment (that is to say not as a locum).

  In addition, the consultant must hold a current licence to practise and also be included on the:

  - General Medical Council's specialist register (please see www.gmc-uk.org)

  or

  - General Dental Council's dentist's register (please see www.gdc-uk.org).

  If you have any questions as to whether your consultant meets these criteria then please contact us.
- ✓ blood tests or visual field tests directly connected to a diagnostic consultation
- ✓ allergy tests performed by a GP or consultant (not tests or advice about nutrition or food intolerance).

What the diagnostic consultation benefit does not cover
- × follow-up consultations and check-ups after you have been diagnosed, for example cancer remission checks or management of a condition
- × treatment charges, for example private hospital charges, operation fees, anaesthetic fees
- × consultations with a podiatric surgeon
- × diagnostic tests and procedures, for example X-rays and scans, endoscopy, tests on body tissue samples, ECGs, health screening
- × counselling, for example psychological counselling, speech therapy and dyslexia services
- × assisted conception, fertility treatment or termination, pregnancy care
- × **general exclusions**.

X-rays and scans

What the X-rays and scans benefit covers
- ✓ X-rays and scans when you have been referred by a consultant who must be (or have been) a consultant in an NHS hospital or the Armed Services. The consultant post must be a substantive appointment (that is to say not as a locum).

  In addition, the consultant must hold a current licence to practise and also be included on the:

  - General Medical Council's specialist register (please see www.gmc-uk.org)

  or

  - General Dental Council's dentist's register (please see www.gdc-uk.org).

  If you have any questions as to whether your consultant meets these criteria then please contact us.

What the X-rays and scans benefit does not cover
- × dental X-rays
- × any form of imaging using computerised tomography (CT), magnetic resonance (MR) or positron emission tomography (PET)
- × **general exclusions**.

Health assessment

This benefit is to help towards the costs of a detailed assessment of your health.

What the health assessment benefit covers

✓ tests which you have in order to assess your general health. The tests must be carried out within one appointment:

- by a doctor registered with the General Medical Council (GMC) or
- by a nurse registered with the Nursing and Midwifery Council (NMC) or
- by a pharmacist registered with the General Pharmaceutical Council (GPhC)
- at an establishment registered with the General Pharmaceutical Council (GPhC) or Care Quality Commission (CQC). For example, these could include a hospital, GP practice, pharmacy or health screening clinic.

The doctor, nurse or pharmacist must hold a current licence to practise.

The health assessment must include at a minimum (although it can include additional tests):

- body composition measurement including height, weight (BMI) and body fat percentage
- blood pressure measurement
- cholesterol or diabetes check, and
- kidney or liver function test.

When you make a claim, you should give us a list of the tests included in your health assessment, along with your receipt. If you do not give us a list of the tests that you have had, we may not be able to pay your claim.

What the health assessment benefit does not cover

× any test that you have which is:

- not carried out at a CQC or GPhC registered establishment
- not carried out by a registered person
- not part of a health assessment, or
- has been carried out at a separate appointment (for example, having a blood test, or a magnetic resonance, CT or other high-tech scan on its own)

× **general exclusions**.

We have a partnership with Nuffield hospitals which will give you a discount on their health assessments. For details, visit our webpage simplyhealth.co.uk/healthassessment

For help with GMC, NMC, GPhC and CQC registration checks please visit:

www.gmc-uk.org

www.nmc-uk.org

www.pharmacyregulation.org

www.cqc.org.uk

Hospital

This benefit can help towards costs such as meals for visitors, telephone calls, travel costs or even hospital parking fees, if you are admitted to hospital.

You can claim a maximum of 20 days or nights each **policy year**.

To make an online claim for hospital cover you'll need a copy of your discharge letter as evidence of your admission. If you do not have your discharge letter, you'll need to get written confirmation of your hospital stay (for example a letter on headed paper from the hospital).

What the hospital benefit covers:

✓ an admission to hospital as a day-patient for tests or treatment.

A day-patient is 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. If you are admitted as a day-patient and then stay overnight, we will pay one night's hospital cover (not one day and one night)

✓ an overnight stay in a hospital as an in-patient for tests or treatment.

An in-patient is a patient who is admitted to hospital and who occupies a bed overnight or longer for medical reasons

✓ out-patient cancer treatment, for example chemotherapy or radiotherapy

✓ an overnight stay in a hospital for one parent who has accompanied their **child** where the **child** is an in-patient for tests or treatment. Both the parent and **child** must be covered by the **policy**.

What the hospital benefit doesn't cover:

× pre-existing conditions during the first 12 months that you are covered by the **policy**. We may ask for evidence that your condition is not pre-existing if you claim for this benefit during the first 12 months of cover.

A pre-existing condition is any condition for which you:

- have been referred to a consultant or hospital for either tests or treatment before the date that you joined the **policy** or

- are receiving consultant or hospital tests or treatment before the date that you joined the **policy**

or

- reasonably believe that you would be referred to a consultant or hospital for tests or treatment within 12 months of joining the **policy**.

× the first 14 nights of any stay in hospital during which you give birth

× out-patient visits, for example consultations, tests, scans

× out-patient treatment (although treatment for cancer is covered)

× day care, for example psychiatric, respite care (short term temporary relief for a carer of a family member), maternity care and care for the elderly

× kidney dialysis

× attendance at an accident and emergency department, or treatment not in a hospital, for example operations carried out in a GP's surgery or clinic

× pregnancy termination

× laser eye surgery

× cosmetic surgery

× hotel ward admission

× pregnancy or childbirth related admissions for a **child** covered by this **policy**

× a parent staying with their **child** following the **child's** birth (unless the **child** requires further tests or treatment in a hospital)

× **general exclusions**.

Medical apparel

This benefit is to help towards paying the costs of these items that you need to wear for medical reasons. You can claim a maximum of two items / repairs to items each **policy year**.

What the medical apparel benefit covers

✓ surgical shoes

✓ mastectomy items

✓ prosthetic, back support, truss items

✓ arch supports and orthotic insoles

✓ surgical hosiery, when supplied through a medical prescription

✓ wigs, when supplied through a medical prescription

✓ hearing aids

✓ repairs to medical apparel.

What the medical apparel benefit does not cover

× invalid equipment, medical equipment and batteries

× **general exclusions**.

New child payment

This benefit has a **qualifying period** of 12 months.

If, after the **qualifying period,** you have a baby or adopt a **child** we will pay new child payment for that baby or **child.** We only make one payment for each **child** no matter how many policies you or your **partner** are covered on. If you have more than one policy you will have to choose which one to claim the new child payment under.

We will also make a payment following a stillbirth of your **child** after 24 weeks of pregnancy.

To claim the new child payment we may ask you for supporting documents, for example a birth or stillbirth certificate, or adoption papers.

We will make a new child payment after:

✓ the birth of your **child**

✓ the legal adoption of a child by you or your **partner**. However, we will not pay new child payment if that **child** is already related to either you or your **partner** (for example if you adopt your **partner's child**)

✓ the stillbirth of your **child** after 24 weeks of pregnancy.

We will not make a new child payment for:

× a miscarriage of up to 24 weeks' gestation

× foster children

× a baby born to a **child** who is covered under the **policy**

× pregnancy termination

× a **child** born or adopted before or during the **qualifying period**.

Prescription charges

This benefit is to help towards the costs of your prescription charges.

To make a claim for prescription cover you'll need to send us a copy of your receipt as well as evidence to show that the prescription is for you (for example a copy of the prescription slip or the prescription label). To make a claim for an NHS Prescription Prepayment Certificate (PPC) you'll need to send us evidence of your certificate (for example a photo of your card or a copy of the letter that you receive with it).

What the prescription benefit covers

✓ NHS prescriptions issued by a GP or a dentist

✓ NHS Prescription Prepayment Certificates (PPC)

✓ private prescriptions issued by a GP or dentist (this includes medicines prescribed by the GP service).

What the prescription benefit does not cover

× pharmacy items that you buy without using a prescription, for example medicines (sometimes called 'over the counter' medicines)

× **general exclusions**

Redundancy premium protection

We will waive the **policy** premiums for a maximum of six months if the **policyholder** is unemployed as a result of compulsory redundancy. We may ask for reasonable evidence in order to support your claim including confirmation from your employer.

If the **policyholder** starts work again within six months, they must tell us immediately – we will not waive the premium once they start work again.

We will not waive the premium:

- during the 12 month **qualifying period**
- for redundancy of less than one whole month
- if the **policyholder** takes voluntary redundancy
- if the person who pays the premium is not the **policyholder**.

General exclusions

× This **policy** will not pay for:

- any benefit if your **treatment date** is before the date that your cover under the **policy** started
- any treatment or service that you receive from a:
  - member of your immediate family – a parent, child, brother or sister, or your **partner**
  - business that you own
- any consultation with, or treatment by, a trainee (even if they are supervised by a qualified professional)
- any consultation which is not face to face, for example telephone, video or internet consultations (this exclusion does not apply to the services available through myWellbeing)
- insurance premiums for any goods or services, or payment for any type of extended warranty or guarantee for goods or services
- regular payment plans for treatment, for example dental practice plan payments
- postage and packing costs
- administration or referral costs, joining fees or registration fees
- claims where you have paid costs with:
  - discount vouchers or coupons
  - any type of retail points scheme or loyalty scheme
- fees or charges for:
  - missing an appointment
  - completing a claim form or providing a medical report
  - providing further information in support of a claim.

Section 3: Definitions

We give certain words and phrases specific meanings in the policy rules. We use **bold type** to show you which these are and so we don't have to keep explaining what they mean.

When we refer to 'you' or 'your' in this document, we mean anyone who is a **member** under this **policy**. When you see 'we', 'us' or 'our' we mean Simplyhealth Access trading as Simplyhealth, a company incorporated in England and Wales.

Child/children
Natural or legally adopted dependent children of the **policyholder** or their **partner**. Children must be under the age of 18.

General exclusions
Anything excluded under this **policy** as set out in the 'Your cover' section.

Member
Anyone who we have accepted for cover under this **policy**.

Partner
Anyone in a relationship with, and who lives with, the **policyholder**. This could be their husband, wife, civil partner or unmarried partner.

Policy
The insurance contract between Simplyhealth and the **policyholder**.

Policyholder
The first person named on the summary of cover.

Policy year
The 12 calendar months from the **start date** or the last **renewal date**. Your summary of cover shows the dates for your policy year.

Qualifying period
A set period of time in which we will not pay claims:

- for any treatment or service that you receive
- if you have a baby or adopt a **child**

during that time. We will not waive premiums if the **policyholder** is made redundant during this time. The qualifying period starts from the date that you join this **policy** or the date of any increase in cover. The **table of cover** shows any qualifying periods that apply to this **policy**.

Renewal date
The date on which this **policy** will renew. You'll find this on your summary of cover.

Start date
The date on which this **policy** starts. You'll find this on your summary of cover.

Table of cover
The table applicable at the **treatment date**. This will show:

- the levels of cover available
- the benefit entitlements available under each level of cover
- any age rules for joining and changing your level of cover
- whether or not **partners** or **children** can be covered by the **policy**.

Treatment date
The date that the treatment or service was supplied. For new child payment this will be the date of adoption or birth of the child.

Section 4: Membership

4.1 **Can I add my family to this policy?**

If the **table of cover** shows cover for **partners** and **children**, then the **policyholder** can add them to this **policy**. They must be added on the on the same level of cover as the **policyholder**.

A **partner** must:

- be within the joining age limits shown on the **table of cover**, and
- live with the **policyholder**.

A **child** must be under 18 (we may ask for proof of this).

We do not have to agree to add a **partner** or **child** to this **policy** or explain why.

4.2 **When can I add someone to this policy?**

The **policyholder** can add their **partner** or **children** to this **policy** anytime during the **policy year**.

4.3 **When can I remove someone from this policy?**

The **policyholder** cannot remove their **partner** or **child** from this **policy** until the **renewal date**.

4.4 **Can I add a child to more than one Simplyhealth policy?**

No. A **child** who is already covered on another Simplyhealth policy cannot join this **policy**.

4.5 **Is there a limit to the number of children that I can add to this policy?**

Yes, the limit is four **children**. However, if you already have more than four **children** on this **policy**, or other Simplyhealth policies, those **children** will remain covered but we will not allow any of your other **children** to join this **policy** until there are fewer than four **children** covered.

4.6 **How long will my children be covered on this policy?**

Each **child** will be covered until the first r**enewal date** after their 18th birthday.

4.7 **Can I have cover if I live outside the UK?**

No. You must live in the UK. If a **member** leaves the UK to permanently live abroad then they will no longer be covered from the date that they leave.

4.8 **What if my contact details change or if I no longer live with my partner?**

You must tell us as soon as you reasonably can about these changes. If you don't then we may not be able to tell you about any changes we intend to make to this **policy**, including changes to the premium.

4.9 **How long does my cover last?**

This is an annual **policy** that lasts for 12 months.

Your cover starts from the date that we include you on the **policy**. It carries on until the **renewal date**. It then carries on from one **renewal date** to the next until either we or the **policyholder** cancel it.

Section 5: Paying premiums, IPT and changing cover

5.1 **How can I pay?**

You must pay by direct debit, although we may ask you for the first payment by debit or credit card rather than wait until the direct debit is set up before starting this policy.

In some cases, where it has been agreed, the **policyholder's** employer may pay us the premium directly from the **policyholder's** salary.

5.2 **What happens if I don't pay the premium?**

Whether the **policyholder** pays us directly or through their employer, if we don't receive the full premium, we won't pay claims and we may suspend or cancel this **policy**. We will tell you if this happens and what you need to do to continue cover.

5.3 **Does the premium include Insurance Premium Tax (IPT)?**

Yes. This is a policy for people who live in the UK and so we charge IPT. If IPT changes, we may need to change the premium to reflect the change. We will tell you about this in your renewal communication.

5.4 **Can I change my level of cover?**

Yes but you can only make one change to your level of cover during the **policy year**. However, you can't change to a higher level of cover if anyone covered by this **policy** is aged above the upper joining age limit shown in the **table of cover**, or if we have waived the premium for any reason.

5.5 **Will changing my level of cover change my policy year?**

No. Changing your level of cover will not change your **policy year**.

5.6 **Will claims that have been paid in the current policy year under my old level of cover count towards the limit for my new level of cover?**

Yes. If your level of cover changes, claims paid in the current **policy year** under your old level of cover will count towards the annual limit for your new level of cover.

5.7 **What happens to the qualifying periods if I increase my level of cover?**

If your level of cover increases, the **qualifying periods** start again from the date you change your level of cover.

5.8 **What happens if I make a claim on a benefit that has a qualifying period after I've changed my level of cover?**

If you make a claim on a benefit that has a **qualifying period** after a change to your level of cover, we'll assess your claims as if your level of cover hadn't changed. So, if you completed the **qualifying period** for the lower level, we will pay your claims up to the benefit limit for that lower level.

Section 6: Claims rules

6.1 **Will my claim be paid if I haven't paid my premium?**

No. We only pay claims if we have received the full premium for your cover.

6.2 **Can I claim if I have paid for treatment but not yet had it?**

No. We'll only pay for treatment that you have already received, been charged for and have paid in full.

6.3 **Will you assess my claim using the treatment date or the date I paid for it?**

We'll assess your claim using the **treatment date** which may be different to the date that you paid for it.

We'll pay your claim from the amount of benefit you have available at the **treatment date** in the **policy year** in which you:

- receive the treatment or service that you are claiming for
- have a baby or adopt a child
- are admitted to and/or discharged from hospital.

6.4 **How will my claim be paid?**

We will pay claims into the bank account that the **policyholder** has asked us to.

6.5 **How quickly should I submit my claim?**

As quickly as possible. We'll pay your claim as soon as we can, but there is no set timescale for this. If there is a long time between the **treatment date** and when you make a claim, it may be more difficult for us to assess it (for example, a health professional may no longer have access to your records). This is why we recommend that you send your claim to us as quickly as possible and at least within six months of your **treatment date**. If we're unable to validate your claim, your claim will not be paid.

6.6 **What happens if I'm paid more than I'm entitled to by mistake?**

If we pay you more than you're entitled to by mistake, we'll either ask you to repay that money, or we'll deduct it from any other claim that you make on any of the policies you hold with us. You're not entitled to keep any overpayment.

6.7 **What happens if I get a refund for the treatment or service I've had from the person who provided it but you've already paid me?**

If you get a refund, you need to tell us. We'll ask you to repay that money, which we'll reallocate to your benefit entitlements or we may decide to deduct it from the next claim you make. If a payment is not received we may decide to suspend or cancel this **policy** until it's been paid.

6.8 **What happens if I mistakenly claim for the incorrect benefit?**

If you mistakenly claim for the incorrect benefit (for example you claim for a pair of glasses under the dental benefit), we won't decline the claim, we'll just assess it under the correct benefit.

6.9 **What happens if a claim is paid after this policy has been cancelled?**

If we pay a claim after this **policy** has been cancelled, we'll contact you to repay that money.

6.10 **Can I claim for treatment or services using more than one benefit?**

No, you must choose which benefit to claim under for each treatment or service.

6.11 **What happens to my claim if more information is needed?**

If we have asked for further information from you or from the person who provided the treatment or service in order to validate a claim, we may not pay any claims on this **policy** until we've received that information and been able to fully assess the claim.

6.12 **I have two Simplyhealth policies, can I claim on them both?**

Yes. If you have two policies with us, you can claim on both up to your benefit limits. It is up to you to tell us if you'd like to claim on your other policy and you may need to complete another claim form. We will not repay more in total than you've paid for the treatment or service if you decide to claim on both policies.

6.13 **What happens if I make a claim on this policy but also have a policy with a different company that covers the same claim?**

If you make a claim on this **policy** and you have a policy with a different company which would cover the same claim then you must tell us. We may contact the other company about the claim so that we don't pay costs that they have already paid. If we find that we've paid more than we should have done then we'll take action to recover the overpayment from you.

6.14 **Can I claim for treatment or services I've received outside of the UK?**

No. We'll only accept claims for treatment or services that you've received in the UK.

Section 7: Your claims for legal compensation against third parties ("subrogation")

7.1 **What should I do if I have a claim against a third party for compensation?**

You must tell us as soon as you can if you have a claim for compensation against a third party (for example, if they've caused you a personal injury in a car accident) and the compensation includes the cost of treatment or services that you have claimed for under this **policy**, as we may have a legal right to recover those costs (either from you or from the third party involved, depending on whether or not you have yet received any compensation).

Section 8: How does cover end?

8.1 **Can I cancel this policy?**

The **policyholder** can cancel this **policy** for any reason by notifying us during the 14 day 'cooling off' period which begins on the **start date** or the next **renewal date**, or the day that they receive their policy documents if that is later.

We'll refund the premium for the 'cooling off' period although we will deduct the costs of any claims paid during that time from the refund. If the cost of those claims is greater than the premium, then you won't be entitled to a refund.

After the 'cooling off' period the **policyholder** needs to give one month's notice in order to cancel this **policy**, in which case we will not backdate cancellation or refund any premiums.

To cancel this **policy**, please contact us.

8.2 **Can Simplyhealth cancel this policy or remove a person from this policy?**

Yes. We'll be entitled to cancel the **policy** or remove a person from this **policy**:

- if we haven't received the premium by direct debit for three months in a row. If this happens, we'll tell the **policyholder**
- if we stop receiving the premiums that have been taken from the **policyholder's** salary or their employer tells us that the premium deductions have stopped. If this happens we'll tell the **policyholder** that cover has ended and we'll backdate the cancellation date to the date that we received the last premium
- if the **policyholder** asks us to and this will take effect from the date we confirm they have been removed. We won't refund the premium and if there is an adjustment to the premium to be made this will take effect from the next month
- if the **policyholder** dies. If there are any other **members** on this **policy,** we may contact them about alternative cover
- if the **policyholder** and their **partner** no longer live together at the same address
- when a **child** reaches the age of 18. We'll cancel the **child's** membership at the next **renewal date**
- if we detect fraudulent activity on this **policy**

- if a **member** behaves inappropriately or in a way that we consider to be abusive to us. If they are abusive, we may immediately cancel this **policy** and any other policies or cover linked to the **member**
- If we decide to not offer renewal terms at the next **renewal date**. We'll give the **policyholder** at least three months' notice before the **renewal date**.

8.3 **What happens once this policy is cancelled?**

Once this **policy** is cancelled, cover ends for all **members**. It is the **policyholder's** responsibility to tell all **members** that cover has ended. We will not pay any claims for any treatment or services received after the cancellation date.

Section 9: Renewal

9.1 **What happens when this policy is due for renewal?**

We will write to the **policyholder** at least 30 days before the **renewal date** to tell them about the terms of the **policy** for the next 12 months (including any changes to these **policy** rules, benefit levels or premiums).

9.2 **Do I need to do anything?**

Not if the **policyholder** is happy with the information we've sent, in which case we'll automatically renew the policy at the **renewal date**. The **policyholder** won't need to do anything.

9.3 **But what if I don't want to renew?**

If the **policyholder** doesn't want to renew with us they'll need to tell us. If the **policyholder** doesn't tell us then we'll assume they're happy to renew this **policy** for another 12 months and we'll continue to take the premiums.

Section 10: Changes to the terms of this policy

10.1 **Can the terms of this policy change?**

Yes, but we'll only make changes at the **renewal date** and any changes will be effective from this date.

10.2 **What sort of changes could be made at renewal?**

We could make any of these changes:

- changes to **policy** cover such as benefits, benefit limits, payback levels
- changes to **policy** rules
- changes to premiums
- any other changes we may need to make for commercial reasons.

10.3 **How will I be told about a change?**

To tell the **policyholder** about a change we will contact them at the postal address or email address that they gave us.

10.4 **What if I don't want to accept any changes?**

If the **policyholder** doesn't want to accept any changes made to this **policy**, they have the right to cancel.

10.5 **Where can I find a copy of the policy rules that applied at the treatment date?**

Copies of our **policy** rules are available on our website or your online account if you have registered for one.

Section 11: Our commitment to great service

11.1 **What should I do if I'm not happy with the service I've received?**

If you're not happy with the service you've received from us then please contact us. You'll find full details of our complaints process on our website or we'll send you a copy if you ask us to.

We'll then investigate and issue a final response within eight weeks.

11.2 **And if I'm still not happy?**

If you're still not happy after you've received our final response, you can refer your complaint to the Financial Ombudsman Service (FOS) at:

Exchange Tower
London
E14 9SR

Telephone: 0800 023 4567 or 0300 123 9123.

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

Website: www.financial-ombudsman.org.uk

The FOS will only look at your complaint if you've given us the chance to resolve it first. Making a complaint to the FOS will not affect your legal rights.

If you bought the policy online and you wish to make a complaint, you can use http://ec.europa.eu/odr which is the European Commission's Online Dispute Resolution (ODR) platform. The ODR platform will not resolve your complaint, but provides another way to access the FOS.

11.3 **What happens if Simplyhealth cannot pay claims?**

If we cannot pay claims, the Financial Services Compensation Scheme (FSCS) protects you. If the FSCS is satisfied that we are unable to pay claims, any valid outstanding claims you have at that point would be paid by the scheme.

For more details please visit www.fscs.org.uk or contact the FSCS directly on 0800 678 1100 or 020 7741 4100.

Section 12: Fraud

12.1 **What is Fraud?**

Fraud is a criminal activity that can result in a fine or a prison sentence.

We would consider someone (which includes the treating professional) to be committing fraud by making a claim, or a statement in support of a claim or sending us a document in support of a claim knowing that it was, or part of it was, false or misleading or exaggerated in any way with the intention of deceiving us into paying them more than they are entitled to.

12.2 **How do we protect ourselves from fraud?**

We have strong anti-fraud measures to protect ourselves and our customers. These may include:

- internal reviews of all activity on this policy
- external of this policy and the claims made under it using private investigators
- passing details of suspected fraudulent claims to the relevant authorities (including the Police) for them to investigate and prosecute through the criminal courts
- sharing information with NHS counter-fraud teams, health professionals' trade associations, other insurance companies and other agencies with a legitimate interest in preventing fraud.
- such other action as we may consider necessary.

12.3 **What happens if we suspect fraud?**

If we suspect fraud we will take appropriate action to protect our rights, which may include one or more of these actions:

- suspending the **policy** whilst we review the matter. We'll tell the **policyholder** if we stop taking the premiums and when we'll start to take them again. We won't pay claims until we've received any premiums that we didn't collect while the **policy** was suspended
- recovering the full amount that we've paid to the **policyholder** for a fraudulent claim (including any element of the claim that is not fraudulent) regardless of which **member** actually made the claim
- no longer accept claims for treatment that has been provided by a particular professional
- cancelling the cover for that **member**
- cancelling the whole **policy** (this means cancelling cover for everyone on the **policy**)

- cancelling all policies held by the **member** with the Simplyhealth Group
- taking legal action to recover any costs that we reasonably incur as a result of the fraud, plus interest and legal costs
- notify the **member's** employer
- such other action as we consider necessary.

Section 13: General rules

13.1 If we have not applied any of these **policy** rules on one or more occasions, we can still apply it in the future.

13.2 No term of this **policy** or any part of it is enforceable other than by us or by the **policyholder**.

13.3 We will use English for all **policy** documents and letters.

13.4 The law of England governs this **policy**. We strongly recommend that you use our complaints process for any **policy** disputes. If our process doesn't resolve a dispute, only the courts of England and Wales are entitled to deal with it.

How we use your data

Simplyhealth respects your privacy and is committed to protecting your personal data. This privacy notice sets out the way in which any personal data you provide to us is used and kept safe by us. For a more detailed explanation of how we use your data please take the time to read our full privacy policy online at the bottom of our website or you can request a copy from our Data Protection Officer.

Why is my personal data needed and what is it used for?
We need and use your data to:

- service the policy / contract that you have
- identify, analyse and calculate insurance risks
- improve our services to our customers
- comply with legal obligations which we are subject to
- protect our interests
- detect and prevent fraud.

Sometimes we may use automation and profiling to evaluate information about you, which may include to determine whether an application for a product is accepted by us, to tailor our marketing material to your needs, to identify and investigate fraudulent activity, to understand claiming behaviour and patterns, or to tailor our pricing, products and services to provide you with a more efficient, consistent and fair customer experience. If you want to know more please contact us..

Who will use my personal data?
We and other companies within the Simplyhealth group may use your information to keep you informed about products and services that may be of interest to you, including from carefully selected third parties.

What personal data will Simplyhealth need to know?
In order to provide our services under this policy we need to know, for example, your name, address, date of birth. We may also take your phone number and email address. In order to take payments and to pay claims, we'll also need your bank account details. If payment is taken from a salary by the policyholder's employer we'll know who that employer is and we might need to hold your payroll details. When you make a claim, you consent to us processing personal medical details about you for that claim.

We may record and monitor both inbound and outbound calls for training and monitoring.

Who holds my personal data?
Simplyhealth Access who are part of the Simplyhealth group of companies.

How is my personal data protected?
By law we must have measures in place to protect your personal data. As a result we have strict rules to protect the storage and use of all personal data. These rules apply to anyone who uses the personal data, even if they are not part of the Simplyhealth Group (we make sure that our contracts include clauses to protect personal data). We may send your personal data outside the European Economic Area. If we do this, we put contracts in place to ensure that your personal data will be kept confidential. Our processes also include protection for our buildings and IT systems. To check that these measures work we run independent audits on a regular basis.

Who can see my personal data?
We can give your personal data:

- to persons who provide a service to us or act as our agents
- to anyone to whom we may transfer rights and duties under this policy
- to persons who may record, use and give personal data to other insurers (such as agencies whose role is to prevent fraud)
- to persons that the policyholder appoints (such as a broker) in order to service this policy
- where we have a duty to provide that personal data (such as to regulatory bodies), or if the law allows us to do so, or if the person who asks for the personal data has a lawful interest in seeing it

In these situations, we may send your personal data outside the European Economic Area.

How long is my personal data kept for?
We keep your personal data for seven years after this policy has been cancelled.

What rights do I have regarding the use of my personal data?
You have the right to see your personal data that we hold. You also have the right to ask us to amend any of your personal data that is incorrect. You can ask us to delete your personal data, or not use it in certain ways. You have the right to move, copy or transfer your personal data. We will agree to any reasonable request unless it means that we cannot service this policy. You'll need to contact the Data Protection Officer to do this.

If I have given my consent for my personal data to be used for a reason, can I change my mind?
Yes, you can change your mind at any time. But if this means that we cannot service this policy, we may have to cancel it.

Who can I contact to talk about my personal data?
If you have any questions or comments regarding any aspect of your personal data, please contact our Data Protection Officer either by email: thedataprotectionofficer@simplyhealth.co.uk, or by post, at:

The Data Protection Officer
Simplyhealth Access
Hambleden House
Waterloo Court
Andover
Hampshire
SP10 1LQ

If I am not happy with the way my data is used, who can I talk to?
If you're not happy with the way we use your personal data, you can contact our Data Protection Officer, or the Information Commissioner's Office (ICO). You can call the ICO on 0303 123 1113 or 01625 545 745, or email the ICO at casework@ico.org.uk

Simplyhealth Access is registered as the Data Controller with the ICO, number Z9564932**.**

About us

Simplyhealth is a trading name of Simplyhealth Access, which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Our Financial Services Register number is 202183. You can check this online on the Financial Services Register by visiting https://register.fca.org.uk/ or by contacting the Financial Conduct Authority on 0800 111 6768. Simplyhealth Access is the insurer that underwrites this policy.

We can only provide you with information on our own products and you will not receive any advice or a personal recommendation from us for our health plans. We may ask you some questions to narrow down the product option on which we provide you with information, but you will then need to make your own choice about how to proceed.

Important contact information

If you have any questions about your policy and how it works, here's how you can get in contact with us:

You can call us on:
0370 908 3481

You can write to us at:
Simplyhealth
Hambleden House
Waterloo Court
Andover
Hampshire
SP10 1LQ

You can also email us:
customerservices@simplyhealth.co.uk

If you're unhappy with the service you've received, then please let us know

You can call us on:
0370 908 3310

Or email us: customerrelations@simplyhealth.co.uk

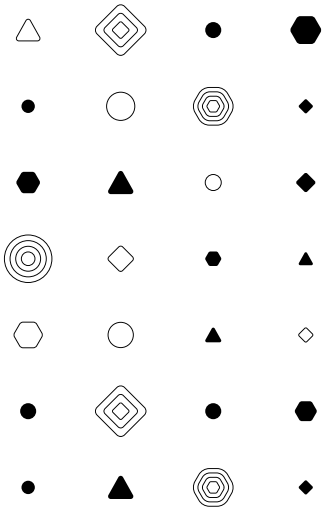
You can also contact us using Facebook or Twitter:
Facebook - @SimplyhealthUk or facebook.com/simplyhealthuk
Twitter - @AskSimplyhealth

Telephone numbers for the myWellbeing services

Speak to a GP:
0330 102 5443

Health and lifestyle guidance:
0330 102 5445

Telephone counselling:
0330 102 5445



Simplyhealth

Simplyhealth is a trading name of Simplyhealth Access, which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Simplyhealth Access is registered and incorporated in England and Wales, registered no. 183035. Registered office, Hambleden House, Waterloo Court, Andover, Hampshire, SP10 1LQ. Your calls may be recorded and monitored for training and quality assurance purposes.