

# PruProtect Essentials Plan Provisions



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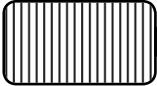

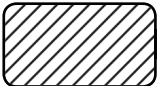


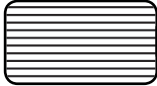
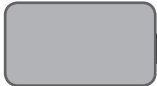
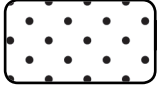
This document is *your* plan provisions. It explains how *your* PruProtect Essentials Plan works. It includes details about the covers and options in the *plan*, how *you* pay *your plan premiums*, and how to make a claim if *you* need to. If *you* have selected Unemployment Cover or Health Cover, *you* should refer to the separate policy documents outlining these covers.

If there is anything that is not clear, please speak to *your* financial adviser, if *you* have one. Or *you* can call *us* on 0845 601 0072. If *you* call *us*, please have *your plan* number to hand. To help *us* improve *our* service, we may record or monitor phone conversations with *you*.

In these provisions, *we*, *us* or *our*, means The Prudential Assurance Company Limited. *You* or *your* means the person or people covered under the *plan*, unless stated otherwise. *We* have put some other words in *italics*. *We* explain what *we* mean by these words in the Definitions section.



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## A. How your plan works

Your *plan* includes at least one of the core covers. These are:

- Life Cover
- Serious Illness Cover
- Income Protection Cover

Your *plan schedule* shows which core covers you have.

### A1. Your plan account

The amount of Life Cover and Serious Illness Cover you have and the amount of *benefit* you could receive are linked to your *plan account*. If you only have Income Protection Cover, you do not have a *plan account*.

When you take out Life Cover, or Serious Illness Cover, or both, we set up a *plan account* for you.

For a *single life plan*, the amount of your *plan account* will be the same as your amount of Life Cover, if you have it. If you do not have Life Cover, the amount of your *plan account* will be the same as your amount of Serious Illness Cover.

For a *joint life plan*, the amount of your *plan account* will be the same as the amount of Life Cover held by the *first person covered*. If they do not have Life Cover, it will be the same as their amount of Serious Illness Cover.

You cannot have more Serious Illness Cover than Life Cover. If you have both covers, you choose the amount of Serious Illness Cover you want as a percentage of your *plan account*. This can be up to 100% of the *plan account*.

If you have a *joint life plan*, each person covered can choose to have Serious Illness Cover. They can have different amounts of Serious Illness Cover from each other. Each of these amounts is based on a percentage of the *plan account*.

If you have Optional Serious Illness Cover for Children:

- this cover is also attached to your *plan account*,
- the percentage you choose applies to all your *children* with this cover.

Optional Serious Illness Cover for Children is not available if your *plan account* structure is decreasing. We explain how the *plan account* structure works below.

If we make payments to you as a result of a successful claim, then the value of your *plan account* reduces by the amount we have paid you. This means that if you need to claim again, the value of the covers in your *plan account* will be lower. There are ways to protect the value of the covers in your *plan account*. For more about this, please see the provisions on Protected Life Cover provision C9 and the Minimum Protected Account option provision C8.

You can also choose whether the value of your *plan account* increases over time, decreases over time or stays level. For more about this, please see the information on 'Your plan account structure' below.

## Your plan account structure

Your *plan account* has one of these three structures, as shown in *your plan schedule*:

Your plan account structure	What this means
Level	The value of the <i>plan account</i> is designed to stay the same over the life of the <i>plan</i> . It will only change if something happens such as <i>you</i> make a claim or change a cover.
Indexed	The value of the <i>plan account</i> increases on each <i>plan anniversary</i> , in line with the <i>Retail Prices Index</i> (RPI). Each increase is limited to a minimum of 0% and to a maximum of 10%. We use the RPI figure that applies five months before each <i>plan anniversary</i> .
Decreasing	The value of the <i>plan account</i> decreases over the life of the <i>plan</i> . It decreases in the same way that the outstanding capital on a repayment mortgage would if the mortgage had: <ul style="list-style-type: none"> <li>■ a 7% annual equivalent interest rate, and</li> <li>■ the same term as the <i>plan</i>.</li> </ul> You can only have a <i>decreasing account</i> if <i>your plan</i> has a <i>fixed term</i> .

Your *plan account* may change if we pay a *benefit*, or because of a change to *your plan*. There is more about changes to *your plan* in provision D.

## A2. How other covers work

The other covers *you* may have in *your plan* are not linked to the *plan account*. The amounts of these covers are set individually.

## A3. How long your plan lasts

Each cover in *your plan* lasts for a defined term. This term can be up to a fixed *date* – this is called a *fixed term*. Life Cover and Serious Illness Cover can instead be for the whole of *your life* – this is called *whole of life*. *Your plan schedule* shows the date on which each of *your* covers terminates.

If *your plan* has a *decreasing account* structure (see 'Your plan account structure' above), the following covers must have the same *fixed term*:

- Life Cover
- Serious Illness Cover
- Disability Cover

Once *your plan* has started, *you* cannot change the term of any cover from *whole of life* to *fixed term*, or from *fixed term* to *whole of life*.

## B. Core covers

This section provides details of each of the core covers. *Your plan schedule* shows which core covers *you* have.

### B1. Life Cover

Life Cover pays a lump sum if the person covered dies, or is diagnosed with a *terminal illness*. This cover may be for a *fixed term* or for *whole of life*. Life Cover is not available for *children*.

#### B1.1 When we will pay the benefit

When we will pay the *benefit* depends on whether *your plan* is single life or joint life.

Single or joint life?	When we will pay the benefit
<i>Single life plan</i>	<p>We will pay the <i>benefit</i> if the person covered dies, or is diagnosed with a <i>terminal illness</i> that meets <i>our</i> definition.</p> <p>When we have paid this <i>benefit</i>, the <i>plan</i> ends.</p>
<i>Joint life first death</i>	<p>With a <i>joint life first death plan</i>, there are two people covered. If both people have Life Cover, we will pay the <i>benefit</i> if one of those people dies, or is diagnosed with a <i>terminal illness</i> that meets <i>our</i> definition.</p> <p>When we have paid this <i>benefit</i> for one person covered, we cancel all the covers for that person. We also cancel the Life Cover for the remaining person covered. If the remaining person has other covers in the <i>plan</i>, the <i>plan</i> continues.</p> <p>The remaining person can apply to <i>us</i> for new Life Cover under a new <i>plan</i>.</p> <p>For more about this, see provision D6.</p>
<i>Joint life second death</i>	<p>This option is only available if <i>you</i> have chosen <i>whole of life</i> cover, see provision A3. With a <i>joint life second death plan</i>, there are two people covered. We will pay the Life Cover <i>benefit</i> after both of the people covered have died, or have been diagnosed with a <i>terminal illness</i> that meets <i>our</i> definition.</p> <p>When we have paid this <i>benefit</i> the <i>plan</i> will come to an end.</p>

#### B1.2 How much we will pay

If both people covered in a *joint life plan* die, and it is not possible to determine who died first, we will pay the total amount of the *plan account*.

In all other circumstances, we will pay the *current benefit amount*.

#### B1.3 When we will not pay

We will not pay the *benefit* if either of the following applies:

- The death or diagnosis of *terminal illness* happens after the Life Cover's *date of expiry*. *Your plan schedule* shows this date.
- The claim is due to a *terminal illness* that is diagnosed less than 12 months from the Life Cover's *date of expiry*.

Under certain circumstances, we may also not pay the *benefit* if the claim is due to suicide. For more about this, see provision D5.6.

## B2. Serious Illness Cover

Serious Illness Cover pays a lump sum if *you* are diagnosed with an illness or condition that we cover and that meets *our* definition of that condition. *Your* claim also needs to meet other criteria. We set these out in this provision.

The lump sum we pay *you* will be a percentage of *your* Serious Illness Cover between 10% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from levels A to F. For more about severity levels, see 'How much we will pay', at provision B2.3.

Serious Illness Cover may be for a *fixed term* or for *whole of life*. However, if *your plan* also has Life Cover and both covers have a *fixed term*, the Serious Illness Cover must have a *date of expiry* on or before *your* Life Cover's *date of expiry*.

### B2.1 When we will pay

*Your* claim must meet the following criteria before we will pay it:

- *You* must be diagnosed with a condition that we cover. The *serious illnesses* we cover are specified in Appendix 1. They are grouped into *body system categories* to help *us* assess claims.
- *Your* condition must meet any of the definitions set out in Appendix 1 that apply to it. We will use the criteria in Appendix 1 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- We must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether we have excluded any conditions from *your* cover. If we have, we will not pay a claim for that condition.
- *You* must survive for at least 14 days after the date of the *life-changing event* which causes *you* to claim. If *you* make a permanent disability claim, *you* must survive until the date when we confirm that *you* are totally and *permanently* disabled. For more about permanent disability claims, see Appendix 1.

*Benefits* under Serious Illness Cover will be due when we confirm that the claim is valid – irrespective of when the claim is made.

#### How we will assess your claim if your occupation has changed

*You* do not need to tell *us* if *you* change *your occupation* while *you* are covered under *your plan*. We will assess any claims *you* make according to the *occupation* *you* were in immediately before *you* claimed. If we would not normally use an *own occupation* definition for that *occupation*, then we may use *activities of daily living* to assess *your* claim. For more about *activities of daily living* assessments, see provision D5.4.

#### Medical evidence

We will ask *your* General Practitioner, and any specialists who are treating *you*, for medical evidence. We will need different types of information for different types of illness. For more about this, see Appendix 1. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid and, if appropriate, which severity level applies to *your* condition.

## B2.2 When we will not pay

We will not pay if:	Where to find more information:
You suffer from a condition that we do not cover.	Appendix 1
You suffer from a condition that we excluded from <i>your</i> cover after assessing <i>your</i> application.	<i>Your plan schedule</i>
<i>Your</i> condition does not meet <i>our</i> definition for that condition.	Appendix 1
You do not survive for at least 14 days after the date of the <i>life-changing event</i> which caused <i>you</i> to claim.	Provision B2.1
You are making a permanent disability claim, and <i>you</i> do not survive until the date when we confirm that <i>you</i> are totally and <i>permanently</i> disabled.	Appendix 1
You are making a subsequent claim that does not meet the criteria for a further payment.	Provision B2.7
We do not receive written notice that <i>you</i> want to claim within six months of the <i>life-changing event</i> which causes <i>you</i> to claim.	
We do not receive the medical evidence we need from <i>your</i> General Practitioner and any specialists who are treating <i>you</i> .	Provision B2.1
We are not satisfied that the <i>serious illness</i> that has led to <i>your</i> claim occurred either while we were providing <i>you</i> with Serious Illness Cover, or was disclosed to <i>us</i> when <i>you</i> applied.	
<i>Your</i> Serious Illness Cover expires before the <i>life-changing event</i> which leads to <i>your</i> claim.	<i>Your plan schedule</i>

## B2.3 How much we will pay

The amount we will pay depends on:

- how severe *your* condition is,
- the type of cover *you* have, and
- the amount of cover *you* have.

### How severe your condition is

The lump sum we pay *you* will be a percentage of *your* Serious Illness Cover between 10% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from A to F:

Severity level	What percentage of your Serious Illness Cover we will pay
A (most severe)	100%
B	75%
C	50%
D	25%
E	15%
F (least severe)	10%

Some conditions are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

### The type of cover

*Your plan schedule* shows whether *you* have Primary or Comprehensive Serious Illness Cover.

With Primary cover *you* are covered for severity levels A, B, C and D. With Comprehensive cover *you* are covered for all the severity levels - from A to F.

### The amount of cover

*Your plan schedule* shows the amount of Serious Illness Cover *you* have. This is the amount *you* would get if we paid 100% of *your* Serious Illness Cover.

## B2.4 What happens if a single life-changing event causes you to claim for more than one serious illness

If a single *life-changing event* causes you to have valid claims for more than one *serious illness*, we will only pay one claim. We will pay the claim for the illness with the highest severity level.

## B2.5 What happens if a single life-changing event causes claims for more than one person covered

If a single *life-changing event* causes claims for more than one person covered – including any *children* covered – and those claims are each made within three calendar months of the *life-changing event*, then we will make more than one *benefit* payment.

We will calculate each payment using the amount of the *plan account* at the time of the *life-changing event*. This means that the total amount we pay across all the claims might be more than the value of the *plan account*. If this happens, the *plan account* will reduce to zero – unless you have the Minimum Protected Account option. For more about the Minimum Protected Account option, see provision C8.

## B2.6 What happens if a single life-changing event means you are eligible for payments under both Serious Illness Cover and Disability Cover

If a single *life-changing event* makes you eligible for payments under both Serious Illness Cover and Disability Cover, we will make both payments. This applies separately to each person covered. If this situation arises and the other person covered is also eligible for at least one payment under Serious Illness Cover or Disability Cover, we will make a payment for each claim. We will calculate the payments simultaneously, rather than reducing your *plan account* by one *benefit* amount before we calculate the other one.

## B2.7 What happens if you need to make a subsequent claim

If you claim once and then claim again, we call the second claim a subsequent claim. This can be for the same condition, or a different one. For more about how we pay subsequent claims, see the flowcharts in Appendix 3 and Appendix 4.

When we make payments under Serious Illness Cover, the value of your *plan account* reduces by the amount we have paid you. The maximum amount available for future claims will be the remaining value of the *plan account*. This works differently if you have the Minimum Protected Account option. For more about this, see provision C8.

### Subsequent claims under the same body system category

If you have already claimed under a particular *body system category*, we will classify any subsequent claims you make under this category as either a *progressive claim* or an *unrelated claim*.

### Progressive claims

#### Definition

A *progressive claim* occurs when:

1. A person covered has a *life-changing event* that causes a *serious illness*.
2. They make a claim for that *serious illness*.
3. They later make a claim for the same illness, or another *serious illness* in the same *body system category* that was caused by the same *life-changing event*.

#### When we won't pay

If the severity level of your *progressive claim* is the same as or lower than the severity level of your original claim, we will not make another payment.

#### When we will pay

If the severity level of your *progressive claim* is higher than the severity level of your original claim, we will make another payment.

#### How we calculate the amount we will pay

We will base the amount we pay on the increase in severity from the original claim to the new claim.

We will base the amount we pay on the value of your *plan account* prior to the original claim. We will also pay interest for the period from the original date of claim to the date we pay this *progressive claim*.

## Unrelated claims

Definition	An <i>unrelated claim</i> occurs when: <ol style="list-style-type: none"> <li>1. A person covered has a <i>life-changing event</i> that causes a <i>serious illness</i>.</li> <li>2. They make a claim for that <i>serious illness</i>.</li> <li>3. They later make a claim for another <i>serious illness</i> that was caused by a different <i>life-changing event</i>.</li> </ol>
When we won't pay	If the severity level of <i>your unrelated claim</i> is the same as or lower than the severity level of <i>your original claim</i> , we will not make another payment.
When we will pay	If the severity level of <i>your unrelated claim</i> is higher than the severity level of <i>your original claim</i> , we will make another payment.
How we calculate the amount we will pay	<p>The amount we will pay depends on the length of time between the <i>life-changing event</i> and the <i>unrelated claim</i>.</p> <p>If <i>your unrelated claim</i> is within 36 months of the original <i>life-changing event</i>, we will base the amount we pay on:</p> <ul style="list-style-type: none"> <li>■ the increase in severity from the original claim to the new one, and</li> <li>■ the value of the <i>plan account</i> at the time <i>you</i> claim.</li> </ul> <p>If <i>your unrelated claim</i> is more than 36 months after the date of the subsequent <i>life-changing event</i>, we will treat this as a separate claim. That means we will base the amount we pay on the value of <i>your plan account</i> at the time <i>you</i> claim and on the severity level of the subsequent claim. We will not base the amount we pay on the increase in severity from the original claim to the new one, so the severity level of the original claim is not relevant.</p>

### Subsequent claims under a different body system category

If *you* claim under a *body system category* that we have not made any previous payments for, we will treat this as a separate claim. That means we will base the amount we pay on:

- the value of *your plan account* at the time *you* claim, and
- the severity level that applies to *your* subsequent condition or illness.

There are two types of claim that we treat differently:

#### 1. Subsequent claims under the major organ transplant body system category that are caused by a condition or illness that is named under another body system category

The underlying cause of a claim under the major organ transplant *body system category* may be a condition or illness named under another category.

- If we have previously paid out for that condition – no matter what category it is listed under – we will treat *your claim* as a *progressive claim*. For more about *progressive claims*, see the start of this provision.
- If we have not previously paid out for that named condition, we will treat *your claim* in the same way that we treat standard 'subsequent claims under a different body system category' – see above.

#### 2. Subsequent permanent disability claims

When we use the phrase 'permanent disability claims', we always mean claims under the *body system category* of 'permanent disability', not claims under Disability Cover. For more about Disability Cover, see provision C2.

If *you* make a claim that is valid under both the permanent disability category and another *body system category*, we will treat this as a permanent disability claim. We will manage any subsequent claims on the basis that we have already paid a claim under the permanent disability category.

- If we have made a previous payment for a permanent disability claim, and *your* condition then progresses to a higher severity level within that category, we will:
  - pay an amount based on the increase in severity from the original claim to the new one, and

- If we have made a previous payment under any *body system category* other than permanent disability, and *your* condition then progresses so it becomes valid under the permanent disability category, we will:
  - pay an amount based on any increase in severity from the original claim to the new one, as above, and
  - manage any subsequent claims on the basis that this was a permanent disability claim.

The underlying cause of *your* permanent disability claim may be a condition or illness that is named under another *body system category*. We will treat *your* subsequent claim as a separate claim if, after making a permanent disability claim, *you* go on to make a claim either:

- under the same *body system category* that the underlying cause of *your* permanent disability claim is listed under – as long as this claim occurs more than 36 months after *your* permanent disability claim, or
- under a different *body system category* – irrespective of how long it has been since *your* permanent disability claim.

That means that we will treat *your* claim in the same way that we treat standard 'subsequent claims under a different body system category' – see above. However if *you* make an *unrelated claim* under the same *body system category* that the underlying cause of *your* permanent disability claim is listed under, and *your* subsequent claim occurs less than 36 months after *your* permanent disability claim, we will treat this as a standard subsequent claim. In this case, we will only pay the subsequent claim if it is of a higher severity level than *your* permanent disability claim.

If we pay a severity A claim because *you* fail the relevant *functional activity tests*, we will not assess any further claims using these tests – irrespective of which category of illness *your* claim is under.

Once we have paid a severity A claim under the permanent disability *body system category*:

- we will not pay any further claims under this *body system category*, and
- we will only pay a subsequent Serious Illness Cover claim if it is for a condition or illness that it not related to the underlying cause of *your* permanent disability claim.

## B2.8 How your cover continues after a claim for serious illness

### How we calculate your remaining cover – Life Cover and Serious Illness Cover

Usually, payments we make under Serious Illness Cover will reduce the value of the *plan account* by that amount. This will affect the amount that is available for future Life Cover and Serious Illness Cover claims.

We calculate the amount available for future *serious illness* claims by subtracting the total amount paid for claims under Serious Illness Cover and Optional Serious Illness Cover for Children from *your plan account*. The amount of *your* Serious Illness Cover will be a chosen percentage of the *plan account*.

This will work differently if *you* have either:

- the Minimum Protected Account option – for more about this option, see provision C8, or
- Protected Life Cover – this option means that payments we make under Serious Illness Cover will not affect the amount that is available for future Life Cover claims. For *plans* with Protected Life Cover we will subtract any payments for *serious illness* claims only from *your* amount of Serious Illness Cover, not from the *plan account* as a whole. For more about this, see provision C9.

### How we calculate your remaining cover – Disability Cover

When we make a Disability Cover payment, this does not affect the *plan account*. However, Disability Cover is subject to a maximum amount, so any payments we make will reduce the level of Disability Cover available. For more information about Disability Cover, see provision C2.

### For joint life plans

Payments we make under Serious Illness Cover will reduce the value of *your plan account* by that amount – unless *you* have the Minimum Protected Account option or Protected Life Cover. For more about these, see provision C8 and provision C9. If the *plan account* does reduce, then:

- for the person covered who made the claim – the premium for covers attached to the *plan account* under the *plan* will stay the same,
- for the other person covered – the premium for covers attached to the *plan account* will reduce in proportion to the reduction in the *plan account*.

### What happens if we've paid the maximum amount of Serious Illness Cover benefit

There is a maximum total amount of *benefit* you can receive under Serious Illness Cover. This is the lower of:

- £2,000,000, or
- three times *your* initial amount of Serious Illness Cover – adjusted to reflect:
  - any indexation increases that occurred up to the date of *your* first *serious illness* claim
  - any changes *you* have made to *your* amount of cover.

On *joint life plans* this maximum applies to each person covered separately. The maximum *benefit* includes any payments we make under Disability Cover, Family Income Cover payable on diagnosis of a *serious illness* and Education Cover payable on diagnosis of a Severity A *serious illness*.

If *you* reach this maximum *benefit* amount, we will not accept any further *serious illness* claims for Education Cover and Family Income Cover. Disability Cover and Serious Illness Cover will be removed from *your plan*. If we do that, we will reduce *your* premiums accordingly.

This applies separately to each person covered. *You* will no longer have to pay a premium for those covers.

If we have not yet paid the maximum *benefit*, but a future claim might breach it, we might restrict *your* cover.

### B2.9 What happens if you have the Health Cover Optimiser?

If *you* have Health Cover as part of *your plan* and *you* have also selected the Health Cover Optimiser, this Health Cover Optimiser allows *you* to use part of *your* Serious Illness Cover *benefit* to pay towards *your* private medical treatment costs. *Your plan schedule* will show whether *you* have selected the Health Cover Optimiser.

#### How the Health Cover Optimiser works with Serious Illness Cover

If *you* have selected the Health Cover Optimiser as part of *your plan*, *your* Health Cover and Serious Illness Cover will be linked. This means that if *you* make a Serious Illness Cover claim (for an eligible *serious illness*), we may hold back some of the *benefit* due to *you* and use it to help cover costs already incurred in diagnosing and treating *your serious illness*. At *your* request, we may also hold back an additional amount to help pay for any future private medical treatment for that *serious illness*.

We will pay the rest of the *benefit* under *your* Serious Illness Cover to *you* as normal. If, after *your* treatment is complete, any of the amount we held back remains, we will also pay *you* this amount once at least 12 months have passed without *you* needing further treatment for that *serious illness*.

If *you* prefer not to have this additional amount held back, *your* Health Cover will not pay for medical treatment of that *serious illness* until at least 12 months have passed without *you* needing further treatment for that same *serious illness*. For more information please see *your* Health Cover policy document.

We may, without *your* consent, cancel *your* Health Cover Optimiser and offer *you* an alternative option with another private medical insurance provider. We will give *you* 30 days' notice if we do this, and will give *you* details of any changes.

The private medical insurance provider may cancel *your* Health Cover without offering alternative cover, as long as they give *you* 30 days' notice. If this happens *you* will no longer need to pay a premium for this cover.

### B3. Income Protection Cover

Income Protection Cover pays *you* a regular income if *you* become incapacitated and cannot work, and *your* incapacity meets *our* definitions. For more information about the different ways we define incapacity, see provision B3.1.

If *you* have a *joint life plan* and both people covered have Income Protection Cover, we will treat each person's cover separately.

We offer two types of Income Protection Cover – Primary cover and Comprehensive cover. *Your plan schedule* shows which type of cover *you* have. Unless we say otherwise, the following information applies to both levels of cover.

### B3.1 When we will pay

We will pay if *you* become ill, injured, or disabled, and *your* incapacity meets one of the following definitions:

A standard definition means that illness or injury makes *you* unable to perform the material and substantial duties of *your own occupation*. These are the duties that are normally needed to do *your own occupation* and that cannot reasonably be omitted or modified by *you* or *your* employer. To meet this definition, *you* must also not be working in any other *occupation* for payment or profit.

An *activities of daily living* definition means that we assess *your* incapacity according to a specific set of everyday physical activities. These are designed to help show how able someone is to look after themselves. We list these activities in provision D5.4. We use this definition to assess *houseperson* claims. For more about this, see provision B3.5.

A special definition means that:

1. For the first 12 months, we will pay *you* the full monthly *benefit* if illness or injury makes *you* unable to perform the material and substantial duties of *your own occupation*. As with the standard definition, these are the duties that are normally needed to do *your own occupation* and that cannot reasonably be omitted or modified by *you* or *your* employer. *You* must also not be working in any other *occupation* for payment or profit.
2. After 12 months, we will assess *you* again. If, at this point, *you* are unable to perform at least three of the *activities of daily living* without another person's help, we will continue to pay *you* the full monthly *benefit*. If *you* do not fail at least three *activities of daily living*, but are still unable to perform *your own occupation* as described in the paragraph above, we will reduce the amount we pay *you* to 50% of the monthly *benefit* amount.

We offer people different definitions depending on whether they are in paid work and what kind of work they do. *Your plan schedule* shows which definition applies to *you* if it is not the standard definition.

#### How we will assess your claim

We will assess any claims *you* make according to the *occupation* *you* were in immediately before *you* claimed.

If we would not normally use the standard definition of incapacity for that *occupation*, then we may use the special definition or *activities of daily living* definition to assess *your* claim. For more about *activities of daily living* assessments, see provision D5.4.

#### When we will start paying your claim

*Your benefit* will be due at the end of *your deferred period*.

The *deferred period* starts on the date *you* become incapacitated according to the definition that applies to *your plan*. It ends when *you* have been continuously incapacitated for one of:

- seven days (this is only an option if *you* are *self-employed*)
- one month
- three months
- six months, or
- twelve months.

*You* can choose to set up two *deferred periods* under *your plan*. If *you* have two *deferred periods* then, when *you* claim, we start paying *you* part of *your* monthly *benefit* amount at the end of the first *deferred period*. We will start paying *your* full monthly *benefit* amount at the end of *your* second *deferred period*.

*Your plan schedule* shows which *deferred period* or periods apply to *your* Income Protection Cover.

#### Telling us that you want to claim

If *you* become incapacitated and need to claim, *you* need to give us written notice within a specified period of time. This notification period depends on the *deferred period* *you* have chosen:

Deferred period	Notification period
Seven days	Immediately
One month	Two weeks
Three months	One month
Six months	Two months
Twelve months	Two months

Your plan schedule shows the deferred period that applies to your plan.

If we do not receive notice of your incapacity within the specified period, we may treat the deferred period as if it started on the date we actually receive notice.

If we receive notice more than 90 days after the end of the deferred period, we may decline your claim.

#### Providing us with evidence for your claim

We will need to be satisfied that your claim is valid in order to pay you any benefits under Income Protection Cover.

When you first make your claim, we will ask for evidence to substantiate it. We may also ask for evidence at reasonable intervals to confirm that you are still entitled to Income Protection benefits.

This evidence may include, but is not limited to:

- a report from your General Practitioner
- copies of your medical records
- a report from any other appropriate medical specialist
- your hospital records, including copies of the results of any clinical tests or investigations
- information from your employer, including details of the duties of your employment
- your human resources records, including details of sickness absence.

We may also need you to have a medical examination with an examiner that we choose, at our expense. We may appoint a disability counsellor or someone who represents us to talk to you about any aspect of your claim.

If you do not give consent for us to access your medical information, or to get any other assistance or information that we need to assess your claim, then we may decline, suspend, or stop paying you any benefits under Income Protection Cover.

#### Verifying your earnings

When you apply for Income Protection Cover, or when you ask to increase your cover, you can ask us to verify your earnings. These are your verified earnings. We will then use these earnings to work out the amount of any Income Protection benefits we will pay you if you need to claim.

If you do not confirm your earnings at one of these stages, then we will need information about your pre-incapacity earnings when you make a claim.

The information we need in order to confirm your verified earnings may vary depending on whether you are employed, self-employed, or the director of a limited company.

If you are:	The information we need may include, but is not limited to, things like:
Employed	<ul style="list-style-type: none"> <li>■ Your three most recent payslips, and</li> <li>■ Your most recent P60.</li> </ul>
Self-employed	<ul style="list-style-type: none"> <li>■ Your three most recent agreed HMRC tax computations and self assessments, and</li> <li>■ A copy of the accounts that relate to these.</li> </ul>
The director of a limited company	<ul style="list-style-type: none"> <li>■ Your three most recent printed payslips,</li> <li>■ copies of your company accounts that have been submitted for HMRC, for the last three years, and</li> <li>■ confirmation of the number of employees in the company.</li> </ul>

We may approach your employer, or HM Revenue and Customs, to confirm details of your earnings and allowances. However, we will ask you before we do this.

If you provide the evidence above, and we accept it, then we will use these verified earnings to assess any claims you make under Income Protection Cover. We will not need further evidence of your earnings before we pay your claim.

### B3.2 How much we will pay

Your *plan schedule* shows the monthly *benefit* you could receive if you claimed under Income Protection Cover. This figure is subject to a maximum amount. The maximum will depend on whether you have Primary or Comprehensive Income Protection Cover.

#### Maximum monthly benefit amount: Primary cover

For Primary cover, we calculate the *maximum monthly benefit amount* as the lesser of:

- £10,000 a month, or
- 50% of either your *verified earnings* or *pre-incapacity earnings*, minus the total gross monthly equivalent of:
  - Any *benefits* that are due to you under any other insurance against incapacity or illness. These will involve a regular payment to you or to a financial institution on your behalf. This includes other income protection policies and mortgage payment protection policies.
  - Any salary, wages, income, fees, dividends or commission which you continue to receive directly from *employment* or your business.
  - Any early retirement pension you receive from any office, *employment*, trade, profession or vocation as a result of your incapacity. This will be net of any Income Tax or National Insurance contributions that apply.

State benefits, non-employment related dividends, income from renting property or goods, and any waiver of premium *benefits* will not reduce your *maximum monthly benefit amount*.

#### Maximum monthly benefit amount: Comprehensive cover

For Comprehensive cover, we calculate the *maximum monthly benefit amount* as the lesser of:

- £16,666 a month, or
- 60% of the first £2,500 of your *verified earnings* or *pre-incapacity earnings*, plus 50% of your earnings or *pre-incapacity earnings* in excess of £2,500, minus the total gross monthly equivalent of:
  - Any *benefits* that are due to you under any other insurance against incapacity or illness. These will involve a regular payment to you or to a financial institution on your behalf. This includes other income protection policies and mortgage payment protection policies.
  - Any salary, wages, income, fees, dividends or commission which you continue to receive directly from *employment* or your business.
  - Any early retirement pension you receive from any office, *employment*, trade, profession or vocation as a result of your incapacity. This will be net of any Income Tax or National Insurance contributions that apply.

State benefits, non-employment related dividends, income from renting property or goods, and any waiver of premium *benefits* will not reduce your *maximum monthly benefit amount*.

#### For both Primary and Comprehensive cover

If, when you claim, your *verified earnings* or *pre-incapacity earnings* are not sufficient to support the monthly *benefit* shown on your *plan schedule*, we will pay you the *maximum monthly benefit amount*.

If you are receiving Income Protection Cover payments and category C Disability Cover payments at the same time, we will not allow the sum of these to exceed the *maximum monthly benefit amount*. In this situation we would reduce your total *benefit* payments to the maximum amount. We will always reduce or cancel Disability Cover payments before we reduce any Income Protection Cover payments.

A different *maximum monthly benefit amount* will apply if we are assessing your claim under the *houseperson* category. For more about this, see provision B3.5.

#### Indexation of Cover (except during a claim)

Your *plan schedule* also shows whether you have chosen for your *benefit* amount to:

- remain level throughout the term of the cover, or
- increase annually in line with the *Retail Prices Index*.

You can choose to have indexed Income Protection Cover irrespective of whether *your plan account* is indexed, as Income Protection Cover is not linked to the value of *your plan account*.

Any annual increase in *your cover* will result in an increase in *your* Income Protection Cover premium by the total of:

- the percentage rise in the *Retail Prices Index*, from a minimum of 0% to a maximum of 10%, and
- 2.5%.

You can choose indexed Income Protection Cover when you take *your plan* out, or you can add it during *your* term. The only times when you cannot add indexed Income Protection Cover are:

- when you are incapacitated and not working,
- during the *deferred period*, or
- when we are paying you a *benefit* under *your* Income Protection Cover.

We cannot guarantee to offer indexed Income Protection Cover to everyone. To decide whether or not we can offer it to you, we might need to *underwrite your request*.

Indexation increases will not increase *your benefit* amount while we are paying a claim under this cover – unless you have chosen the escalation of claims in payment option. For more about this, see 'Escalation of claims in payment' below. Once we stop making payments, you can ask for any increases you missed to be added to *your* future *benefit* amount.

### Escalation of claims in payment

This option is chosen separately from the option for indexation of cover described above. If you choose the escalation of claims in payment option, *your* Income Protection Cover *benefit* will increase annually while we are paying an Income Protection claim.

Increases due during a claim will be added to *your benefit* amount annually, on the anniversary of the date we made the first Income Protection payment to you. We will calculate each increase using the *Retail Prices Index* that applies exactly five months before the date we add the increase.

The amount that *your benefit* will increase by depends on whether you have Primary or Comprehensive Income Protection Cover.

With Primary cover, the increase in *your benefit* amount will be in line with the *Retail Prices Index*. This is subject to an annual minimum of 0% and maximum of 10%.

With Comprehensive cover you have two options. The increase in *your benefit* amount can be either:

- in line with the *Retail Prices Index*, subject to an annual minimum of 0% and maximum of 10%, or
- in line with the *Retail Prices Index*, plus 2%. This is subject to an annual minimum of 2% and maximum of 12%.

*Your plan schedule* shows which level of cover you have. If you have Comprehensive cover, it also shows which percentage increase you have chosen from the options above.

You can choose to add the escalation of claims in payment option when you take *your plan* out, or you can add it during *your* term. The only times when you cannot add it are:

- when you are incapacitated and not working,
- during the *deferred period*, or
- when we are paying you a *benefit* under *your* Income Protection Cover.

We cannot guarantee to offer this option to everyone. To decide whether or not we can offer it to you, we might need to *underwrite your request*.

### Permanent disability increase

If you have Comprehensive Income Protection Cover, we will increase *your* monthly *benefit* amount if you become *permanently* disabled. We will increase it if you are *permanently* unable to perform at least three of the *activities of daily living* without another person's help. For more about *activities of daily living*, see provision D5.4.

A permanent disability increase adds 10% to *your* monthly *benefit*, subject to the annual maximum *benefit* of £200,000. For more about the maximum *benefit*, see provision B3.2.

If we have already confirmed that *you* are eligible for standard *benefit* payments, we will pay these while we assess whether *you* are eligible for a permanent disability increase.

Once we are satisfied that *you* are eligible for the increase, we will start paying *you* the increased monthly *benefit* amount from the date of *your* next *benefit* payment.

### Recovery benefit

The recovery *benefit* gives *you* access to a range of services that can help *you* recover from *your* incapacity. We do not pay the *benefit* directly to *you*. Instead, we work with *you* to organise services to help *you* recover. These services might include, but are not limited to:

- Medical support – including private medical care, physiotherapy, osteopathy, psychotherapy and cognitive behavioural therapy.
- Assisted care – including assisted devices, modifying a house or car, and a carer or nursing support.
- Educational support – including further education qualifications and CV writing.

The services *you* access through the recovery *benefit* must be related to the incapacity that has caused *your* claim. An *appropriate medical specialist* must agree to any medical support and assisted care *you* receive.

We will provide the recovery *benefit* either:

- at the end of *your deferred period*, or
- if *your deferred period* is less than three months – when *you* have been continuously incapacitated for three months, to an extent that meets the definition of incapacity that applies to *your plan*.

The amount of the recovery *benefit* we will provide depends on whether *you* have Primary or Comprehensive Income Protection Cover. The amount is fixed when *you* set up *your plan*.

For Primary cover, we will provide a *benefit* that is equal to *your* first full monthly *benefit* payment under Income Protection Cover – up to a maximum of £1,000.

For Comprehensive cover, we will provide a *benefit* that is equal to double *your* first full monthly *benefit* payment under Income Protection Cover – up to a maximum of £2,000.

When *you* use *your* recovery *benefit*, the amount available will reduce by the cost of the services *you* have used.

In some cases we may pay the *benefit* directly to *you*. *You* will need to demonstrate that this will go towards the cost of other services that will help *you* recover from *your* incapacity.

### Payments for partial months

We will pay *your benefit* or *benefits* to *you* on a monthly basis. If *your benefits* do not stop for any other reason, we will pay *you* the final monthly *benefit* on the first day of the month that follows *your* Income Protection Cover's *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover.

*Your* first and last *benefit* payments may be for partial months. If they are, they will be fractions of the monthly amount.

We calculate *your* first monthly *benefit* payment by:

1. determining the number of days between the end of the *deferred period* and the date of the first payment, then
2. multiplying this number by 12, then
3. dividing it by 365, and then
4. multiplying the result by the amount of monthly *benefit* *you* are due to get.

We will calculate *your* final monthly *benefit* payment in the same way except that, for the first step, we will determine the number of days between *your* second last payment and *your* Income Protection Cover's *date of expiry*.

If the end of the *deferred period* and the *date of expiry* for *your* Income Protection Cover are within the same month, we will only make one payment. We will calculate it as above except that, for the first step, we will determine the number of days between the end of the *deferred period* and *your* cover's *date of expiry*.

**What happens if we overpay your claim**

If, for any reason, we pay you more under your Income Protection Cover than the *benefit* amount you are entitled to, we may recover the excess amount from you. We will do this either by offsetting the overpayment against your future *benefits*, or by asking you to return the excess amount to us.

**B3.3 How long we will pay for****When your benefit will start**

We will start paying your *benefit* on the day after your *deferred period* ends. For more about the *deferred period*, see provision B3.1.

**Retrospective payments if you are self-employed**

If you are *self-employed* – and have a seven-day or one-month *deferred period* – payments will still start at the end of the *deferred period*. However, we may make retrospective Income Protection *benefit* payments, backdated to the date you became incapacitated.

You must be continuously incapacitated throughout the *deferred period* to get retrospective payments. You must also undergo or suffer from one of the following treatments or conditions during the *deferred period*, and it must be directly related to the cause of your claim:

- Any hospital outpatient treatment, excluding Accident and Emergency department consultations.
- Hospitalisation as an inpatient, for a continuous period of at least 24 hours.
- Medical quarantine, imposed by a doctor for an infectious disease such as chicken pox or measles but excluding a common cold, influenza and stomach problems or gastro-enteritis.
- Back problems where an MRI scan shows clear medical evidence of a condition such as a prolapsed intervertebral disc.
- Anxiety, stress or depression that meant you were referred to a hospital psychiatric unit.
- Courses of chemotherapy or radiotherapy.

**When your benefit will end**

We will stop paying you *benefits* under Income Protection Cover on the cover's *date of expiry*. Your *plan schedule* shows this date.

We will stop paying you *benefits* earlier than the *date of expiry* if any of the following occurs:

- You become able to start work in your own occupation again. We will base this on your ability to work, not the availability of work.
- You are no longer suffering any loss of income from your own occupation, despite your illness or injury.
- You unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of your illness or injury.
- You refuse reasonable modifications or adjustments – for example to your working environment or working practices – that would mean you were able to carry out the essential duties of your occupation.
- You fail to provide us with satisfactory proof of your entitlement to *benefit* payments within 30 days of us asking for it.
- You do not have a physical examination and medical tests – at our expense – when we ask.
- You fail to provide us with satisfactory proof that your incapacity is ongoing when we ask for it. We might need this so we can confirm that you continue to be entitled to the *benefit*.
- You are removed from the *plan*. For more about how this happens, see provision D.
- Your death.

You need to tell us if either of the following occurs while we are paying *benefits* to you under Income Protection Cover:

- You return to work and start earning again, or
- You start receiving an income or *benefits* under any other insurance because of your incapacity, including mortgage payment protection policies or any other type of policy that pays a *benefit* to you or to a financial institution on your behalf.

If you do not tell us about any other income or *benefits*, we might cancel your Income Protection Cover claim and stop paying your *benefit*.

### Reviewing your claim

We might review *your* claim at any time while we are paying *benefits* under Income Protection Cover, to make sure *you* continue to be eligible for the *benefit*. This means that *you* might periodically need to fill out claim forms.

### B3.4 What happens if you live abroad

If *you* live or are travelling in the *United Kingdom* or *permitted countries*, we will pay *your* Income Protection *benefits* as normal. If *you* live or are travelling within other countries while we are paying *you* *benefits*, we will limit the amount we pay *you* to the equivalent of 26 weeks' *benefit* in any 52-week period. We will also limit the amount we pay to an overall maximum of 52 weeks' *benefit*.

### B3.5 What happens if you are not in employment when you make a claim or you have chosen Houseperson Cover

#### If you are unemployed or on a career break

If *you* become *unemployed* – or take a *career break* – and claim under Income Protection Cover within a month of leaving work, we will assess *your* claim against *your* previous *own occupation*.

If *you* claim more than one month after leaving work, we will assess *you* as a *houseperson*. We may also change the *deferred period* that applies to *your* Income Protection Cover. For more about the *deferred period*, see provision B3.1.

#### Houseperson claims

We will use the *houseperson* category to assess claims for anyone who is:

- a *houseperson*
- a student
- retired
- working less than 16 hours a week, or
- *unemployed* – and has been for at least one month.

#### When we will pay

If *you* become ill or injured to the extent that *you* cannot perform three out of the six *activities of daily living*, we will pay *you* a *benefit*. For more about *activities of daily living*, see provision D5.4. *You* will not need to give us details of *your* earnings when *you* claim.

#### How much we will pay

The *maximum monthly benefit amount* is £1,500. This is the maximum even if *you* had a higher amount of Income Protection Cover in place before *you* became eligible under the *houseperson* category. If *you* become *unemployed* or become a *houseperson*, *you* may want to reduce *your* cover so that it does not exceed this maximum.

If *your* Income Protection Cover is indexed, indexation increases can raise the *maximum monthly benefit amount* for *houseperson* claims over £1,500. For more about indexation, see provision B3.2.

We will pay an extra £100 a month for any *children* that are dependent on *you*. This amount is per *child*, but is subject to a monthly maximum of £300 or 20% of *your* monthly *benefit* amount – whichever is lower.

#### How long we will pay for

We will stop paying *you* *benefits* under the *houseperson* category if:

- *you* start work in any *employment* or *occupation* for profit or reward, or
- *you* no longer fail three out of the six *activities of daily living*.

If *you* start or return to work for profit or reward *you* need to tell us immediately. If *you* originally had full Income Protection Cover, *you* can ask us to reinstate this when we stop paying *you* *benefits* under the *houseperson* category.

If *you* were originally covered as a *houseperson*, *you* can ask to increase *your* cover to full Income Protection Cover. Any increase will be subject to all the provisions in these plan provisions that relate to Income Protection Cover. We will need details of *your* *employment* or *occupation* and evidence about *your* health before we can increase *your* cover. We will also need evidence of *your* earnings or what *you* expect to earn so we can make sure *your* cover would not exceed the *maximum monthly benefit amount*.

## B3.6 What happens if you go back to work

### In the same capacity as before you were ill or injured

If you recover sufficiently to go back to work in *your own occupation* or another *occupation*, in a capacity that means you are no longer suffering any loss of income, and you have a *deferred period* of seven days or one month, we will stop paying all Income Protection *benefits* to you.

### Back to work benefit

If you recover sufficiently to go back to work in *your own occupation* or another *occupation*, in a capacity that means you are no longer suffering any loss of income, and you have a *deferred period* of three, six or 12 months, we will pay you a back to work *benefit*. We will only pay this *benefit* once we have stopped paying you all other *benefits* under Income Protection Cover, including rehabilitation *benefit* and proportionate *benefit*. For more about these, see 'In a reduced capacity' below.

The amount of back to work *benefit* we will pay depends on whether you have Primary or Comprehensive cover.

- Primary cover:
  - One month after we pay your last monthly *benefit*, we will pay you an amount equal to 25% of your last full monthly *benefit* payment.
  - Two months after we pay your last monthly *benefit*, we will pay you an amount equal to 10% of your last full monthly *benefit* payment.
- Comprehensive cover:
  - One month after we pay your last monthly *benefit*, we will pay you an amount equal to 50% of your last full monthly *benefit* payment.
  - Two months after we pay your last monthly *benefit*, we will pay you an amount equal to 25% of your last full monthly *benefit* payment.

If you make any subsequent claims under Income Protection Cover, we will only pay a back to work *benefit* for your subsequent claim if it occurs more than six months after we paid the last *benefit* for your previous claim.

### In a reduced capacity

If you go back to work in a reduced capacity – with lower earnings – we will continue to pay you some of your *benefit*.

#### Working in your own occupation for lower earnings: rehabilitation benefit

If you go back to *your own occupation*, but are unable to undertake it to the same extent that you were immediately before becoming incapacitated – and can prove this to our satisfaction – we will pay you a rehabilitation *benefit*. This is a fraction of your full *benefit* amount, based on how much you earn on your return to work.

We will pay the rehabilitation *benefit* for a maximum of 52 weeks. We may ask you to have medical treatment or supervision to help you recover your former level of capacity.

#### Working in a different occupation for lower earnings: proportionate benefit

If you go back to work, but your new job is not in *your own occupation* and provides you with lower earnings, we will pay you a proportionate *benefit*. This is a fraction of your full *benefit* amount, based on how much you earn on your return to work. We must be satisfied that your incapacity makes you unable to continue in your *own occupation*.

We calculate the amount of rehabilitation or proportionate *benefit* we will pay in the following way:

1. We take your reduced earnings (how much you earn on your return to work) away from your verified earnings or pre-incapacity earnings (depending on which amount we have used to assess your claim).
2. We divide the result by your verified earnings or pre-incapacity earnings.
3. We then multiply that result by your monthly Income Protection *benefit*.

If you do not tell us that you have returned to work, we might cancel your Income Protection Cover claim and stop paying your *benefit*.

### B3.7 What happens if you need to claim again

If *you* recover and return to work but then need to make another Income Protection Cover claim, we will waive the *deferred period* for this subsequent claim. This waiver only applies if the two claims are linked to the same condition, and *you* make the second claim within six months of the original *benefit* payments ending.

If we determine that *your* claims are linked to the same condition, and *your* level of Income Protection Cover has increased due to indexation of cover since *you* returned to work, we will not apply any increases to the amount we pay for *your* subsequent claim. Instead we will reduce *your* level of Income Protection Cover to the level that applied to the first of *your* linked claims.

### B3.8 Waiver of Income Protection Cover premiums

We will waive *your* Income Protection Cover premiums while we are paying *you* any *benefits* under that cover. This includes payments under the *houseperson* category, *rehabilitation benefit* and, *proportionate benefit*. For more about these, see, provisions B3.5 and B3.6.

We will continue to waive *your* premiums until the first of the following happens:

- *You* become able to start work in *your own occupation* again. We will base this on *your* ability to work, not the availability of work.
- *You* are no longer suffering any loss of income from *your own occupation*, despite *your* illness or injury.
- *You* perform any kind of work for profit or reward – except if we are paying *you* *rehabilitation* or *proportionate benefit*.
- *You* unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of *your* illness or injury.
- *You* fail to provide us with satisfactory proof of *your* entitlement to the *benefit* within 30 days of us asking for it, or *you* do not have a physical examination and medical tests – at *our* expense – when we ask.
- *You* fail to provide us with satisfactory proof that *your* incapacity is ongoing when we ask for it. We might need this so we can confirm that *you* continue to be entitled to the *benefit*.
- *Your* Income Protection Cover reaches its *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover.
- *Your* death.

#### Waiver of Premium on Incapacity

The Waiver of Income Protection Cover premiums described above is separate from the Waiver of Premium on Incapacity explained in provision C5. Waiver of Premium on Incapacity means that we will waive the *plan premiums* for *your* whole *plan* – not just for Income Protection Cover – if *you* become incapacitated and *your* incapacity meets one of *our* definitions. For more about the definitions of incapacity that apply, see provision C5.1.

If *you* have Comprehensive Income Protection Cover plus at least one other cover as part of *your plan*, Waiver of Premium on Incapacity is automatically included. If *you* have Primary Income Protection Cover plus at least one other cover, *you* can choose to add it to *your plan*. *Your plan schedule* shows if Waiver of Premium on Incapacity is part of *your plan*.

If *you* have a PruHealth policy which provides *you* with private medical cover and which started at least six months before the date *you* became incapacitated, we will waive the premiums for that policy or scheme. We will waive them from the date *you* became incapacitated, for a maximum of six months.

If *your* PruHealth premiums increase while we are waiving them, we will not waive the increase. We will only waive PruHealth premiums up to a maximum value of 10% of the monthly amount *you* are receiving under Income Protection Cover.

### B3.9 When your cover will end

*Your* Income Protection Cover will end on the earliest of:

- *Your* cover's *date of expiry*, less the *deferred period*. For example, if *you* have a *deferred period* of three months, *your* cover will end three months before its *date of expiry*. The *deferred period* may not apply if *you* are making a subsequent claim. For more about this, see provision B3.7.
- *You* being removed from the *plan*.
- The *plan* ceasing.
- *Your* death.

## C. Other covers and options

### C1. Optional Serious Illness Cover for Children

Optional Serious Illness Cover for Children pays a lump sum if *your child* suffers from a *serious illness* that we cover. *Your plan schedule* shows if *you* have Optional Serious Illness Cover for Children.

This cover does not need *underwriting*. It includes any of *your children* that *you* have asked *us* to cover. We pay any *benefits* under this cover to the *planholder*.

This cover is attached to *your plan account*. This means that, to have this cover, *you* must have a *plan account*. *Your plan account* must be level or increasing. However, *you* don't have to have Serious Illness Cover to have this cover. For more about *your plan account*, see provision A1.

#### C1.1 When we will pay the benefit

We will pay the *benefit* if *your claim* meets all of the following criteria:

- *Your child* is diagnosed with a *serious illness* as defined in Appendix 1, except for:
  - an illness that is defined as total and permanent disability (*own occupation*).
  - an illness that we would assess using *functional activity tests* in the permanent disability category.
- The *child* *you* are claiming for survives for at least 14 days after the *life-changing event* or the diagnosis of the *life-changing event*.
- We receive *your* written claim within six months of the *life-changing event*.
- *You* give *us* the evidence we ask for, as set out in provision B2.
- *Your claim* meets the criteria in Appendix 1, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.

#### C1.2 How much we will pay

How much we will pay depends on *your* current amount of Optional Serious Illness Cover for Children. This amount:

- is a percentage of *your plan account*, up to 100%, as shown on *your plan schedule*, and
- is the same for each *child*.

There is also a maximum total amount of *benefit* that we will pay for each named *child* under this cover over the term of the *plan*. This is the lower of:

- £100,000, or
- three times the initial amount of Optional Serious Illness Cover for Children – adjusted to reflect:
  - any indexation increases that occurred up to the date of *your* first Optional Serious Illness Cover for Children claim
  - any changes *you* have made to the amount of cover.

If the *child* is covered by more than one PruProtect policy, this maximum applies to the total of all payments under these policies and not to each policy separately – including where a *joint life plan* has been split.

Once we have made a payment for a named *child* under Optional Serious Illness Cover for Children, this maximum will be capped at its pre-claim level.

The amount we will pay also depends on:

- how severe the *serious illness* is,
- the level of *your* Optional Serious Illness Cover for Children.

**How severe the serious illness is**

We will pay a percentage of *your* Optional Serious Illness Cover for Children, depending on how severe the *serious illness* is, based on a scale from A to F:

	The percentage of your Optional Serious Illness Cover for Children we will pay
A (most severe)	100%
B	75%
C	50%
D	25%
E	15%
F (least severe)	10%

Some *serious illnesses* are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

**The severity levels your cover includes**

If *you* have Optional Serious Illness Cover for Children, *your plan schedule* shows whether it is at Primary or Comprehensive level.

If *you* have Comprehensive cover, *your* Optional Serious Illness Cover for Children includes all severity levels, from A to F.

If *you* have Primary cover, *your* Optional Serious Illness Cover for Children only includes severity levels A, B, C and D.

*You* can change the type of *your* cover from Primary to Comprehensive, or from Comprehensive to Primary, at any time, unless *we* are assessing a claim under this cover. The type of *your* cover must be the same for all named *children* under the cover.

**C1.3 When we will not pay**

We will not pay the *benefit* if:

- the *life-changing event* that causes *you* to claim happens after *your* Serious Illness Cover's *date of expiry*, or
- the claim is due to a *pre-existing medical condition*.

**C1.4 What happens if a single life-changing event causes you to claim for more than one serious illness**

If a single *life-changing event* results in a *child* being diagnosed with more than one *serious illness*, we will only pay a *benefit* for the illness with the highest severity level.

However, if one of the *serious illnesses* is a neurological condition that started after the *start date* of the Optional Serious Illness Cover for Children, we will assess it as a separate claim. We will base *our* assessment on reports from the consultant in charge of monitoring progress.

**C1.5 How your cover continues after a claim**

This cover is attached to the *plan account*. That means that when we make payments under this cover, the value of *your plan account* reduces by the amount we have paid *you*. This works differently if *you* have the Minimum Protected Account option. For more about *your plan account*, see provision A1 and for more about the Minimum Protected Account option, see provision C8.

If *your plan account* reduces, we will reduce *your* premiums proportionately.

### C1.6 What happens if you have Protected Life Cover

If *you* have Protected Life Cover, any *benefits* we pay under *your* Optional Serious Illness Cover for Children will not affect any future *benefits* we pay under *your* Life Cover.

There is more about Protected Life Cover in provision C9.

## C2. Disability Cover

Disability Cover pays one or more lump sums if *you* become disabled because of an accident or illness. *You* can be covered for several different categories of disability, from temporary disability that stops *you* working in the short term, to severe disability that affects *you* for the rest of *your* life.

When we use the phrase 'Disability Cover', we always mean the cover described in this provision, not the permanent disability category that is part of Serious Illness Cover. For more about this, see provision B2.

### The level of your Disability Cover

When *you* take out Disability Cover, *you* choose the level of cover *you* want. There are three levels to choose from. Each level includes certain categories of disability:

- Level 1 means *you* can claim for categories A and D.
- Level 2 means *you* can claim for categories A, B and D.
- Level 3 means *you* can claim for categories A, B, C and D.

We explain these categories below, in 'The category of your claim'.

*Your plan schedule* shows if *you* have Disability Cover, and which level *you* have.

### Who can get Disability Cover?

To get Disability Cover, each person covered needs to have Life Cover or Serious Illness Cover or both. If *you* have a *joint life plan*, *you* can add this cover for both people covered, or just one. *Children* cannot have this cover.

### C2.1 When we will pay the benefit

We will pay the *benefit* if *your* claim meets all of the following criteria:

- The illness or condition that led to *your* claim is in a category that *you* are covered for.
- The illness or condition that led to *your* claim started after the *start date* of *your* Disability Cover, or *you* told *us* about it before *your plan* started.
- *You* give *us* any information and documents that we reasonably ask for as evidence for *your* claim.
- *Your* employer, GP and any *appropriate medical specialist* treating *you* give *us* any medical information we reasonably ask for as evidence for *your* claim.
- *Our* Chief Medical Officer decides *your* claim is valid and, if appropriate, decides the severity level of *your* illness or condition.
- The *life-changing event* which causes *your* claim occurs before the *date of expiry* of *your* Disability Cover.
- *You* live longer than the relevant survival period for *your* illness or condition.

### C2.2 How much we will pay

How much we will pay depends on:

- how much Disability Cover *you* have, and
- the category of *your* claim.

### How much Disability Cover you have

*Your plan schedule* shows *your* initial amount of Disability Cover.

Disability Cover is subject to a maximum amount, so any payments we make will reduce the amount of Disability Cover available for future claims.

### The category of your claim

We pay different amounts depending on the category of *your* claim. There are four categories: A, B, C and D.

#### Category A

You can make a category A claim if *your* claim meets all of the following criteria:

- You meet the category A criteria for any of the illnesses or conditions in Appendix 2, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- You survive for at least 14 days after the diagnosis of the *life-changing event*.
- We receive *your* written claim within six months of the *life-changing event*.

The *benefit* is 100% of *your* Disability Cover. If we pay this, *your* Disability Cover will end, and we reduce *your* premiums accordingly.

#### Category B

You can make a category B claim if *your* claim meets all of the following criteria:

- You have level 2 or level 3 Disability Cover.
- You meet the category B criteria for any of the illnesses or conditions in Appendix 2, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- You survive for at least 14 days after the diagnosis of the *life-changing event*.
- We receive *your* written claim within six months of the *life-changing event*.

The *benefit* is 50% of *your* Disability Cover.

#### Category C

You can make a category C claim if *your* claim meets all of the following criteria:

- You have level 3 Disability Cover.
- Your illness or injury means you lose at least 80% of *your own occupation* income for four months in a row.
- We receive *your* written claim within three months of the *life-changing event*.

The *benefit* is a lump sum of 2.5% of *your* Disability Cover.

You can make a further category C claim for the same disability every four months, if *your* claim meets the criteria above. We will make up to six of these *benefit* payments for the same disability.

You cannot make a category C claim if:

- you have already had a category A or B *benefit* for the same illness or condition, or
- it is less than four months before the *date of expiry* of *your* Disability Cover.

The monthly equivalent of this *benefit* is one quarter of the lump sum. This monthly equivalent, together with any *benefit* we are paying you under Income Protection Cover, must not be more than *your* Income Protection Cover's *maximum monthly benefit amount*. For more about this, see provision B3.2. If it is more than that, we will reduce *your* total *benefit* payments to the maximum amount. We will always reduce or cancel Disability Cover payments before we reduce any Income Protection Cover payments.

If we pay you any category C *benefit*, you must continue to pay *your* Disability Cover premiums, unless:

- it is less than four months before *your* Disability Cover's *date of expiry*, or
- you are covered by a waiver of premium. There is more about premium waivers in provisions C5 to C7.

#### Category D

You can make a category D claim if *your* claim meets all of the following criteria:

- An illness or injury causes you to be totally and *permanently* unable to do *your own occupation* for profit or reward.
- You survive at least until the date when we agree that you are totally and *permanently* disabled.
- We receive *your* written claim within six months of the *life-changing event*.

The *benefit* is 100% of *your* Disability Cover. If we pay this, *your* Disability Cover will end, and we will reduce *your* premiums accordingly.

#### Maximum benefit amounts

The maximum amount of Disability Cover *you* can have is £500,000. This maximum applies to *your* initial amount of cover and to any increases *you* make to *your* cover.

For claims as a result of a *serious illness*, the maximum combined Education Cover, Family Income Cover, Disability Cover and Serious Illness Cover *benefit* we will pay for a person covered over the life of the *plan* is £2,000,000.

If *you* reach this maximum *benefit* amount, we will not accept any further *serious illness* claims for Education Cover and Family Income Cover. Disability Cover and Serious Illness Cover will be removed from *your plan*. If we do that, we will reduce *your* premiums accordingly.

#### Other covers and options

If we haven't yet paid the maximum *benefit*, but a future claim might breach it, we might restrict *your* cover.

If *you* have a *joint life plan*, all of these points apply to each person covered separately.

### C2.3 What happens if you make another claim

If we pay *you* a category B *benefit*, *you* cannot make another category B claim for the same condition. However, if the condition has got worse, *you* may be able to make a category A claim for the same condition.

If we pay *you* a category B *benefit* and *you* make a successful claim for a different condition in the same illness category, we will upgrade *your* new *benefit* to category A.

### C2.4 How will we assess your incapacity

If *you* make a claim, we will assess *your* incapacity by referring to *your own occupation*. If we don't normally give an *own occupation* definition for *your* particular *occupation*, we may assess *your* incapacity by referring to the *activities of daily living*. For more about *activities of daily living*, see provision D5.4.

### C3.5 What happens if a single life-changing event causes you to claim for more than one condition

If a single *life-changing event* causes *you* to have more than one condition, *you* might qualify for more than one *benefit* under Disability Cover. If this happens, we will only pay the most valuable *benefit*.

### C2.6 What happens if a single life-changing event means you are eligible for payments under Disability Cover, Serious Illness Cover, Family Income Cover or Education Cover

If a single *life-changing event* makes *you* eligible for *benefits* under Disability Cover, Serious Illness Cover, Family Income Cover or Education Cover, we will pay all *benefits*. This is subject to a maximum amount. For more about the maximum, see provision C2.2.

### C2.7 What happens if both people covered claim

If *you* have a *joint life plan* and both people covered claim, we will treat each claim separately. If we pay a *benefit* for both claims, the two *benefits* will also be separate.

### C2.8 What happens to your cover after a successful claim

Disability Cover is subject to a maximum amount, so any payments we make will reduce the amount of Disability Cover available for future claims. Appendix 4 shows how we deal with further claims. If *you* have a *joint life plan*, this applies separately to each person covered.

### C2.9 What happens when you reach the age of 70

*Your* Disability Cover will end when *you* reach the age of 70, unless *you* have chosen a shorter term. *Your plan schedule* shows the *date of expiry* for this cover. If *you* have a *whole of life plan account*, *you* can choose to convert *your* Disability Cover to a limited version of Serious Illness Cover at this point.

This version of Serious Illness Cover will only provide cover for *serious illnesses* with severity A or B. We exclude the following *body system categories* or conditions from this version of Serious Illness Cover:

- ear
- eye

- respiratory diseases
- permanent disability: mental and behavioural disorders
- permanent disability: total and permanent disability (*own occupation*)
- loss of manual dexterity
- loss of muscle power
- persistent vegetative state

If you choose to convert to Serious Illness Cover, your Disability Cover premium will stay the same. We will tell you how much Serious Illness Cover this premium will give you.

### C3. Family Income Cover

Family Income Cover pays a regular monthly *benefit* for a fixed period of time if you die or are diagnosed with a *terminal illness*. If you have selected Family Income Cover that provides a *benefit* on diagnosis of a *serious illness*, a *benefit* will also be paid if you are diagnosed with a *serious illness* that we cover and that meets our definition of that condition. Your claim also needs to meet other criteria. We set these out in this provision.

We offer two types of Family Income Cover – Primary cover and Comprehensive cover. Your *plan schedule* shows which type of cover you have. Unless we say otherwise, the following information applies to both levels of cover.

#### C3.1 When we will pay the benefit

##### Death or diagnosis of a terminal illness

If the cover is single life we will pay the regular monthly *benefit* if the person covered dies, or is diagnosed with a *terminal illness* that meets our definition. The regular monthly *benefit* will be paid until the end of the Family Income Cover *date of expiry* or for the guaranteed payment term if this is longer – for more information about the guaranteed payment period see provision C3.2.

If the cover is *joint life first death* we will pay the regular monthly *benefit* if one of the people covered dies, or is diagnosed with a *terminal illness* that meets our definition.

The regular monthly *benefit* will be paid until the end of the Family Income Cover *date of expiry* for the person covered, or for the guaranteed payment term if this is longer – for more information about the guaranteed payment period see provision C3.2.

When we have paid this *benefit* for one person covered, we cancel all the covers for that person. We also cancel the Family Income Cover for the remaining person covered. If the remaining person has other covers in the *plan*, the *plan* continues.

The remaining person can apply to us for new Family Income Cover under a new *plan*. For more about this, see provision D6.

##### Serious Illness

If you have selected Family Income Cover that provides a *benefit* on diagnosis of a *serious illness* your claim must meet the following criteria before we will pay it:

- You must be diagnosed with a condition that we cover. The *serious illnesses* we cover are specified in Appendix 1. They are grouped into *body system categories* to help us assess claims.
- Your condition must meet any of the definitions set out in Appendix 1 that apply to it. We will use the criteria in Appendix 1 to assess your claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- We must have agreed to cover you for the condition you claim for. Your *plan schedule* shows whether we have excluded any conditions from your cover. If we have, we will not pay a claim for that condition.
- You must survive for at least 14 days after the date of the *life-changing event* which causes you to claim. If you make a permanent disability claim, you must survive until the date when we confirm that you are totally and *permanently* disabled. For more about permanent disability claims, see Appendix 1.

Regular monthly *benefit* payments under Family Income Cover will start to be paid when we confirm that the claim is valid – irrespective of when the claim is made.

The fixed period of time for which we pay you the *benefit* will depend on how severe your illness is – based on a scale from levels A to F. For more about severity levels, see 'How long we will pay the benefit for', at provision C3.2.

### How we will assess your claim if your occupation has changed

You do not need to tell us if you change your *occupation* while you are covered under your *plan*. We will assess any claims you make according to the *occupation* you were in immediately before you claimed. If we would not normally use an *own occupation* definition for that *occupation*, then we may use *activities of daily living* to assess your claim. For more about *activities of daily living* assessments, see provision D5.4.

### Medical evidence

We will ask your General Practitioner, and any specialists who are treating you, for medical evidence. We will need different types of information for different types of illness. For more about this, see Appendix 1. Our Chief Medical Officer will use this evidence to determine whether your claim is valid and, if appropriate, which severity level applies to your condition.

## C3.2 How long we will pay the benefit for

### Guaranteed payment term

Family Income Cover will be paid for a minimum period – this is known as the guaranteed payment term. Your *plan schedule* will show the guaranteed payment term which applies to your *plan*.

### Death of diagnosis of a terminal illness

If you die or are diagnosed with a *terminal illness* the *benefit* will be paid until the Family Income Cover *date of expiry*, or for the guaranteed payment term if this is longer.

### Serious illness

The period for which we will pay after diagnosis of a *serious illness* depends on:

- how severe your condition is,
- the type of cover you have, and
- the guaranteed payment term.

### How severe your condition is

The period for which we will pay the regular monthly *benefit* will depend on how severe your illness is – based on a scale from A to F:

Some conditions are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

Severity level	Benefit payment term
A (most severe)	Longer of: <ul style="list-style-type: none"> <li>■ from date of diagnosis until the <i>date of expiry</i>; and</li> <li>■ Guaranteed payment term</li> </ul>
B	75% of the longer of: <ul style="list-style-type: none"> <li>■ from date of diagnosis until the <i>date of expiry</i>; and</li> <li>■ Guaranteed payment term</li> </ul>
C	50% of the longer of: <ul style="list-style-type: none"> <li>■ from date of diagnosis until the <i>date of expiry</i>; and</li> <li>■ Guaranteed payment term</li> </ul>
D	25% of the longer of: <ul style="list-style-type: none"> <li>■ from date of diagnosis until the <i>date of expiry</i>; and</li> <li>■ Guaranteed payment term</li> </ul>
E	15% of the longer of: <ul style="list-style-type: none"> <li>■ from date of diagnosis until the <i>date of expiry</i>; and</li> <li>■ Guaranteed payment term</li> </ul>
F (least severe)	10% of the longer of: <ul style="list-style-type: none"> <li>■ from date of diagnosis until the <i>date of expiry</i>; and</li> <li>■ Guaranteed payment term</li> </ul>

### The type of cover

Your *plan schedule* shows whether you have Primary or Comprehensive Family Income Cover.

With Primary cover you are covered for severity levels A, B, C and D. With Comprehensive cover you are covered for all the severity levels - from A to F.

### C3.3 When we will not pay

We will not pay the *benefit* if either of the following applies:

- The death or diagnosis of *terminal illness* happens after the Family Income Cover *date of expiry*. Your *plan schedule* shows this date.
- The claim is due to a *terminal illness* that is diagnosed less than 12 months from the Family Income Cover *date of expiry*.

Under certain circumstances, we may also not pay the *benefit* if the claim is due to suicide. For more about this, see provision D5.6.

For claims following the diagnosis of a *serious illness* we will not pay if:

We will not pay if:	Where to find more information:
You have not selected Family Income Cover that provides cover on diagnosis of a <i>serious illness</i> .	Provision C3.1
You suffer from a condition that we do not cover.	Appendix 1
You suffer from a condition that we excluded from <i>your cover</i> after assessing <i>your application</i> .	<i>Your plan schedule</i>
<i>Your condition</i> does not meet <i>our definition</i> for that condition.	Appendix 1
You do not survive for at least 14 days after the date of the <i>life-changing event</i> which caused you to claim.	Provision C3.1
You are making a permanent disability claim, and you do not survive until the date when we confirm that you are totally and <i>permanently</i> disabled.	Appendix 1
You are making a subsequent claim that does not meet the criteria for a further payment.	Provision C3.7
We do not receive written notice that you want to claim within six months of the <i>life-changing event</i> which causes you to claim.	
We do not receive the medical evidence we need from <i>your General Practitioner</i> and any specialists who are treating you.	Provision C3.1
We are not satisfied that the <i>serious illness</i> that has led to <i>your claim</i> occurred either while we were providing you with Family Income Cover, or was disclosed to us when you applied.	
Your Family Income Cover expires before the <i>life-changing event</i> which leads to <i>your claim</i> .	<i>Your plan schedule</i>

### C3.4 How much we will pay

Your *plan schedule* shows the amount of Family Income Cover you have. This is the regular monthly *benefit* amount that we will pay you in the event of a claim. If your cover is indexed it will increase at each *plan anniversary* – see provision C3.5.

If both people covered in a *joint life plan* die, and it is not possible to determine who died first, or if both people suffer from a *serious illness* we will pay the higher Family Income Cover amount.

### C3.5 Indexed Cover

Your *plan schedule* will show whether your Family Income Cover is on a level or an indexed basis.

Level or indexed?	What this means
Level	The amount of Family Income Cover will stay the same over the life of the <i>plan</i> . It will only change if something happens such as <i>you</i> change the cover.
Indexed	The amount of Family Income Cover <i>benefit</i> increases on each <i>plan anniversary</i> , in line with the <i>Retail Prices Index (RPI)</i> . Each increase is limited to a minimum of 0% and to a maximum of 10%. We use the RPI figure that applies five months before each <i>plan anniversary</i> . The RPI increase will continue during a claim.

### C3.6 What happens if more than one person covered needs to claim

If one person dies or is diagnosed with a *terminal illness* the *benefit* will be paid until the *date of expiry*, or the guaranteed payment term if this is longer. The Family Income Cover for the remaining person covered will be cancelled.

If one person is diagnosed with a *serious illness* and, while we are paying a claim the other life is diagnosed with a *serious illness*, we will pay the *benefit* for whichever claim is eligible for the longest payment period. If the regular monthly *benefit* amount for the person with the longest payment period is lower than the amount for the person with the shorter payment period, we will pay the higher *benefit* amount until the end of the shorter payment period. At the end of this period we will pay the lower monthly *benefit* amount until the end of the longest payment period.

### C3.7 What happens if you need to make a subsequent claim

If *you* claim once and then claim again, we call the second claim a subsequent claim. This can be for the same condition, or a different one.

#### Subsequent claims

If *you* have already claimed under a particular *body system category*, we will classify any subsequent claims *you* make under this category as either a *progressive claim* or an *unrelated claim*.

Progressive claims	
Definition	A <i>progressive claim</i> occurs when: <ol style="list-style-type: none"> <li>1. A person covered has a <i>life-changing event</i> that causes a <i>serious illness</i>.</li> <li>2. They make a claim for that <i>serious illness</i>.</li> <li>3. They later make a claim for the same illness, or another <i>serious illness</i> in the same <i>body system category</i> that was caused by the same <i>life-changing event</i>.</li> </ol>
When we won't pay	If the severity level of <i>your progressive claim</i> is the same as or lower than the severity level of <i>your original claim</i> , we will not make another payment.
When we will pay	If the severity level of <i>your progressive claim</i> is higher than the severity level of <i>your original claim</i> , we will make another payment.
How long the claim will be paid for	We will pay the claim for the period of time equal to the difference between: <ul style="list-style-type: none"> <li>■ the <i>benefit</i> payment term had the condition been diagnosed at the higher severity level when the original claim was accepted; and</li> <li>■ the length of time that we have already paid the claim for the original condition.</li> </ul>

## Unrelated claims

Definition	<p>An <i>unrelated claim</i> occurs when:</p> <ol style="list-style-type: none"> <li>1. A person covered has a <i>life-changing event</i> that causes a <i>serious illness</i>.</li> <li>2. They make a claim for that <i>serious illness</i>.</li> <li>3. They later make a claim for another <i>serious illness</i> that was caused by a different <i>life-changing event</i> or one that is under a different <i>body system category</i>.</li> </ol>
If a claim is made after the end of a previous <i>benefit</i> payment term	If the <i>benefit</i> payment term for the original claim has ended and we are no longer paying the regular monthly <i>benefit</i> amount we will treat the <i>unrelated claim</i> as a new claim. We will calculate the <i>benefit</i> payment term based on the severity of the <i>serious illness</i> which has caused the <i>unrelated claim</i> .
If a subsequent claim is made while the <i>benefit</i> is being paid due to a previous claim	<p>If the <i>benefit</i> payment term for the original claim has not yet ended and we are still paying the regular monthly <i>benefit</i> amount we may extend the <i>benefit</i> payment term.</p> <p>We will calculate the <i>benefit</i> payment term based on the severity of the <i>serious illness</i> which has caused the <i>unrelated claim</i>.</p> <p>If this <i>benefit</i> payment term is longer than the period until which the <i>benefit</i> for the original claim will be paid, the <i>benefit</i> will be paid until the end of the <i>benefit</i> payment term for the subsequent claim.</p> <p>If this <i>benefit</i> payment term is shorter than the period until which the <i>benefit</i> for the original claim will be paid, the <i>benefit</i> will be paid until the end of the <i>benefit</i> payment term for the original claim.</p>

There are two types of claim that we treat differently to the scenarios set out above:

### 1. Subsequent claims under the major organ transplant body system category that are caused by a condition or illness that is named under another body system category

The underlying cause of a claim under the major organ transplant *body system category* may be a condition or illness named under another category.

- If we have previously paid out for that condition – no matter what category it is listed under – we will treat *your* claim as a *progressive claim*. For more about *progressive claims*, see the start of this provision.
- If we have not previously paid out for that named condition, we will treat *your* claim in the same way that we treat *unrelated claims* – see above.

### 2. Subsequent permanent disability claims

When we use the phrase 'permanent disability claims', we always mean claims under the *body system category* of 'permanent disability', not claims under Disability Cover. For more about Disability Cover, see provision C3.

If *you* make a claim that is valid under both the permanent disability category and another *body system category*, we will treat this as a permanent disability claim. We will manage any subsequent claims on the basis that we have already paid a claim under the permanent disability category.

### C3.8 What happens if you claim for a severity A serious illness

When we have paid a severity A *serious illness* claim for Family Income Cover no further Family Income Cover claims can be made for the person covered.

### C3.9 Maximum benefit amounts

For claims as a result of a *serious illness*, the maximum combined Education Cover, Family Income Cover, Disability Cover and Serious Illness Cover *benefit* we will pay for a person covered over the life of the *plan* is £2,000,000.

If *you* reach this maximum *benefit* amount, we will not accept any further *serious illness* claims for Education Cover and Family Income Cover. Disability Cover and Serious Illness Cover will be removed from *your plan*. If we do that, we will reduce *your* premiums accordingly.

### C3.10 Funeral Contribution Benefit

#### When we will pay this benefit

We will pay this *benefit* when one of the people covered dies.

#### How much we will pay

The amount of Funeral Contribution Benefit that we will pay will depend on whether *you* have Primary Family Income Cover or Comprehensive Family Income Cover. *Your plan schedule* shows which type of cover *you* have.

- If *you* have Primary Family Income Cover we will pay £1,000
- If *you* have Comprehensive Family Income Cover we will pay £2,000
- If *you* have selected indexed Family Income Cover these amounts will not increase in line with the *Retail Prices Index*.

### C3.11 Spend Protector

If *you* have selected Comprehensive Family Income Cover *your plan* will include the Spend Protector.

Spend Protector will pay a regular monthly amount for the first 12 months of a claim for Family Income Cover. This amount will indemnify *you* for the following regular monthly outgoings:

- Mortgage/rent payments
- Utilities bills
- Broadband bills
- Insurances
- Grocery bills
- Car tax/petrol

The regular monthly amount will be paid in addition to *your* Family Income Cover *benefit* amount.

#### When we will pay this benefit

We will pay this *benefit* when the person covered dies or is diagnosed with a *terminal illness*. If *you* have selected Family Income Cover that provides a *benefit* on diagnosis of a *serious illness* we will also pay this *benefit* if *you* are diagnosed with a severity level A *serious illness*.

Spend Protector will only be payable once for each person covered during the period of cover.

#### How much we will pay

The amount that we will pay for Spend Protector will be the lower of:

- 100% of the Family Income Life Cover amount being paid for the claim for the person covered, and
- the amount of *confirmed expenditure*.

We will make a maximum of 12 monthly payments.

## C4. Education Cover

Education Cover provides a range of *benefits* to cover the expenses associated with *your child's* education. *You* can choose to provide Education Cover for one of *your children* or for more than one *child*.

The *benefits* will be paid if the person covered dies or is diagnosed with a *terminal illness*. In addition, if *you* have selected Education Cover that pays out on *serious illness* the *benefits* will be paid if *you* suffer from a *serious illness* that meets *our* definition of a severity A *serious illness*. *Your plan schedule* shows whether *you* have chosen this option.

We offer different types of Education Cover for *children* who are at State school, Private school with boarding or Private day school. *Your plan schedule* shows which type of cover *you* have selected. Unless we say otherwise, the following information applies to all types of cover.

#### C4.1 School Fees Benefit

If *you* have selected the Private School with Boarding Education Cover or the Private Day School Education Cover *you* will be entitled to the School Fees *Benefit*. This *benefit* is not available if *you* have selected the State School Education Cover.

The School Fees Benefit provides a regular amount at the beginning of each school term to cover the primary and secondary school fees of a *child*.

##### When we will pay this benefit

We will pay the School Fees Benefit in respect of each *child* named on *your plan schedule* if the person covered dies, or is diagnosed with a *terminal illness*. If *you* have selected Education Cover that also pays out on *serious illness* the *benefits* will be paid if *you* suffer from a *serious illness* that meets our definition of a severity A *serious illness*. *Your claim* also needs to meet other criteria. We set these out in provision C4.7.

The School Fees Benefit will be paid at the start of each school term. Before we will pay the *benefit* we will require evidence of the actual amount of school fees payable for the coming term.

The first *benefit* payment will be payable at the start of the school term immediately following the date of claim.

If *your child* has not yet reached the compulsory school age (as defined by the Education Act 1996) *benefit* payments will only begin once they reach this age.

##### How much we will pay

At the start of each term we will pay an amount equal to the school fees due for each *child* listed in *your plan schedule* up to a maximum amount.

The maximum amount for the School Fees Benefit may change each year. The change will reflect *our* assessment of the change in cost of school fees each year. The maximum amount for the first policy year is shown on *your plan schedule*. The maximum amount for subsequent policy years will be shown on *your anniversary schedule*.

While we are paying a claim for School Fees Benefit we will review the amount that we will pay each school term for the coming school year on 1<sup>st</sup> September. The amount which we will pay each term for the coming school year will be the lower of:

- the actual amount of school fees payable in respect of the *child* for the coming school year,
- the maximum amount of school fees payable in the previous year increased by the lower of :
  - *our* assessment of the change in the cost of school fees for the coming year; and
  - 12%.

The last payment we will make for this *benefit* will be on the earlier of;

- the *child* no longer being enrolled at a primary or secondary school,
- the start of the school term immediately before their 19<sup>th</sup> birthday; and
- the death of the *child*.

If the *child* leaves a private school and enrolls at a state school where no fees are payable, the regular amount of *benefit* will still be paid. The *benefit* amount will be 50% of the last regular *benefit* paid while the *child* was at a private school.

#### C4.2 University Fees Benefit

If one or more of the *children* listed in *your plan schedule* attend a UK university we will pay an amount towards their university fees each year.

**When we will pay this benefit**

We will pay the School Fees Benefit if the person covered dies, or is diagnosed with a *terminal illness*. If you have selected Education Cover that also pays out on *serious illness* the *benefits* will be paid if you suffer from a *serious illness* that meets our definition of a severity A *serious illness*. Your claim also needs to meet other criteria. We set these out in provision C4.7.

We will pay the *benefit* the *child* is attending a UK university and is studying towards one of the following qualifications:

- First degree, such as a Bachelor of Arts, Science or Education
- Foundation Degree
- Certificate of Higher Education
- Diploma of Higher Education
- Higher National Certificate
- Higher National Diploma

Before we will pay the *benefit* we will require evidence confirming that the *child* is attending a UK university and is studying towards one of the qualifications above. We will also require evidence of the actual fees payable.

University Fees Benefit will be payable at the start of each university term.

The first *benefit* payment will be payable at the start of the University term immediately following the date of claim.

**How much we will pay**

At the start of each term we will pay an amount equal to the university fees due for each *child* listed in your *plan schedule* up to a maximum amount.

The maximum amount for the University Fees Benefit may change each year. The change will reflect our assessment of the change in cost of university fees each year. The maximum amount for the first policy year is shown on your *plan schedule*. The maximum amount for subsequent policy years will be shown on your anniversary schedule.

While we are paying a claim for University Fees Benefit we will review the amount that we will pay each term for the coming university year on 1<sup>st</sup> September. The amount which we will pay each term for the coming university year will be the lower of:

- The actual amount of university fees payable in respect of the *child* for the coming university year,
- The maximum amount of university fees payable in the previous year increased by the lower of :
  - our assessment of the change in the cost of university fees for the coming year; and
  - 12%.

The last payment we will make for this *benefit* will be on the earlier of;

- the *child* no longer being enrolled at a UK university,
- the *child* no longer studying towards a qualification listed above,
- the start of the university year immediately before their 25<sup>th</sup> birthday,
- the University Fees Benefit having been paid for 5 years; and
- the death of the *child*.

**How much will we pay if a child does not attend a UK university**

If one or more of the *children* listed in *your plan schedule* has completed their secondary education and attained the age of 18 but does not attend a registered *UK university* we will still pay the University Fees Benefit. The amount payable will be 33% of the maximum amount payable for the University Fees Benefit. The *benefit* will be paid for a maximum of three years.

If the *child* subsequently decides to attend a *UK university* we will reduce the University Fees Benefit by an amount equal to the *benefit* which we have previously paid.

**How much will we pay if a child does not complete their university education**

If the University Fees Benefit has been paid for more than three years then no further payments will be made.

If the University Fees Benefit has been paid for less than three years we will pay 33% of the maximum amount for the University Fees Benefit. This will be paid until a total of three years *benefit* has been paid (including the period where the *child* attended university) or until the *child* reaches the age of 25 if this is earlier.

**C4.3 School Expenses Benefit**

The School Expenses Benefit provides a regular amount at the beginning of each school term to cover expenses associated with going to school (e.g. uniforms, stationary, textbooks and school trips).

**When we will pay this benefit**

We will pay the School Expenses Benefit if the person covered dies, or is diagnosed with a *terminal illness*. If *you* have selected Education Cover that also pays out on *serious illness* the *benefits* will be paid if *you* suffer from a *serious illness* that meets *our* definition of a severity *A serious illness*. *Your* claim also needs to meet other criteria. We set these out in provision C4.7.

The School Expenses Benefit will be paid at the start of each school term. The first *benefit* payment will be payable at the start of the school term immediately following the date of claim.

If *your child* has not yet reached the compulsory school age (as defined by the Education Act 1996) *benefit* payments will only begin once they reach this age.

**How much we will pay**

The amount that we will pay is shown on *your plan schedule*. This amount will increase at each *plan anniversary* in line with the *Retail Prices Index*. Each increase is limited to a minimum of 0% and to a maximum of 10%. We use the RPI figure that applies five months before each *plan anniversary*. If the claim is in payment the *benefit* will continue to increase in line with RPI subject to a minimum of 0% and to a maximum of 10%.

**When we will stop paying this benefit**

The last payment we will make for this *benefit* will be on the earlier of;

- the *child* no longer being enrolled at a primary or secondary school,
- the start of the school term immediately before their 19th birthday; and
- the death of the *child*.

**C4.4 Star Award Benefit**

The Star Award Benefit provides an amount if *your child* excels in an extracurricular activity. If, while we are paying the School Expenses Benefit a *child* listed in *your plan schedule* is:

- selected for a national sports team,
- achieves Grade 8 level in a musical instrument,
- achieves a Gold Award in the Duke of Edinburgh awards scheme, or
- achieves Gold level in the British Maths Olympiad

we will pay an amount of £1,000.

The Star Award Benefit may be paid only once for each *child* listed in *your plan schedule*.

Before we will pay the Star Award Benefit we will require satisfactory evidence of the achievement.

#### C4.5 School Absence Benefit

The School Absence Benefit provides an amount if *your child* is unable to attend school for an extended period of time due to illness or injury.

If, while we are paying the School Expenses Benefit a *child* listed in *your plan schedule* is either;

- Hospitalised for a period of 10 consecutive days or more, or
- unable to attend their school for 20 consecutive full days due to illness

we will pay an amount of £1,000.

We will require written evidence that either of these events has occurred before we will pay this *benefit*.

The School Absence Benefit may be paid only once for each *child* listed in *your plan schedule*.

#### C4.6 Serious Illness Cover for Children

This *benefit* pays a lump sum if one of the *children* named on *your plan schedule* suffers from a *serious illness* that we cover.

This cover does not need *underwriting*. As well as the following information, all of the information in provision B2 about medical evidence, severity levels, and the definitions we use to assess *serious illnesses* also apply to Serious Illness Cover for Children.

##### When we will pay the benefit

We will pay the *benefit* if *your claim* meets all of the following criteria:

- *Your child* is at least three months old and has not reached the first *plan anniversary* after their 18<sup>th</sup> birthday.
- *Your child* is diagnosed with a *serious illness* as defined in Appendix 1, except for:
  - an illness that is defined as total and permanent disability (*own occupation*)
  - an illness that we would assess using *functional activity tests* in the permanent disability category.
- The *child* you are claiming for survives for at least 14 days after the *life-changing event* or the diagnosis of the *life-changing event*.
- We receive *your* written claim within six months of the *life-changing event*.
- You give us any evidence we ask for, as set out in provision B2.
- *Your claim* meets the criteria in Appendix 1, irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.

##### How much we will pay

The amount of Serious Illness Cover for Children is £5,000.

The amount we will pay depends on how severe the *serious illness* is.

##### How severe the serious illness is

We will pay a percentage of *your* Serious Illness Cover for Children depending on how severe the *serious illness* is, based on a scale from A to D.

	The percentage of your Core Serious Illness Cover for Children we will pay
A (most severe)	100%
B	75%
C	50%
D	25%

Some *serious illnesses* are not covered at all severity levels. Appendix 1 shows which severity levels apply to which conditions.

#### When we will not pay

We will not pay the *benefit* if:

- the *life-changing event* that causes you to claim happens after the first *plan anniversary* following your *child's* 18th birthday, or
- the claim is due to a *pre-existing medical condition*.

#### What happens if you claim for more than one serious illness at a time

If a single *life-changing event* results in a *child* being diagnosed with more than one *serious illness*, we will only pay a *benefit* for the illness with the highest severity level.

However, if one of the *serious illnesses* is a neurological condition that started after the *start date* of the Education Cover, we will assess it as a separate claim. We will base *our* assessment on reports from the consultant in charge of monitoring progress.

#### C4.7 What criteria must I meet to receive a benefit on diagnosis of a serious illness

If you have selected for Education Cover to provide a *benefit* if the person covered is diagnosed with a *serious illness* then your claim must meet the following criteria before we will pay it:

- You must be diagnosed with a condition that we cover as a severity A *serious illness*. The severity A *serious illnesses* we cover are specified in Appendix 1.
- Your condition must meet any of the severity A definitions set out in Appendix 1 that apply to it. We will use the criteria in Appendix 1 to assess your claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated.
- We must have agreed to cover you for the condition you claim for. Your *plan schedule* shows whether we have excluded any conditions from your cover. If we have, we will not pay a claim for that condition.
- You must survive for at least 14 days after the date of the *life-changing event* which causes you to claim. If you make a permanent disability claim, you must survive until the date when we confirm that you are totally and *permanently* disabled. For more about permanent disability claims, see Appendix 1.

*Benefits* will be due when we confirm that the claim is valid – irrespective of when the claim is made.

#### How we will assess your claim if your occupation has changed

You do not need to tell us if you change your *occupation* while you are covered under your *plan*. We will assess any claims you make according to the *occupation* you were in immediately before you claimed. If we would not normally use an *own occupation* definition for that *occupation*, then we may use *activities of daily living* to assess your claim. For more about *activities of daily living* assessments, see provision D5.4.

#### Medical evidence

We will ask your General Practitioner, and any specialists who are treating you, for medical evidence. We will need different types of information for different types of illness. For more about this, see Appendix 1. Our Chief Medical Officer will use this evidence to determine whether your claim is valid.

## C4.8 When we will not pay Education Cover benefits

### Claims as a result of death or diagnosis of a terminal illness

We will not pay the *benefit* if either of the following applies:

- The death or diagnosis of *terminal illness* happens after the Education Cover *date of expiry*. Your *plan schedule* shows this date.
- The claim is due to a *terminal illness* that is diagnosed less than 12 months from the Education Cover *date of expiry*.

Under certain circumstances, we may also not pay the *benefit* if the claim is due to suicide. For more about this, see provision D5.6.

When we have accepted a claim for one person covered, we cancel all the covers for that person. We also cancel Education Cover, Family Income Cover and Life Cover for the remaining person covered under the *plan*. If the remaining person has other covers in the *plan*, the *plan* continues.

### Claims as a result of diagnosis of a serious illness

We will not pay if:	Where to find more information:
You suffer from a condition that we do not cover as a severity A <i>serious illness</i> .	Appendix 1
You suffer from a condition that we excluded from your cover after assessing your application.	Your <i>plan schedule</i>
Your condition does not meet our definition for that condition.	Appendix 1
You do not survive for at least 14 days after the date of the <i>life-changing event</i> which caused you to claim.	Provision C4.7
You are making a permanent disability claim, and you do not survive until the date when we confirm that you are totally and <i>permanently</i> disabled.	Appendix 1
We do not receive written notice that you want to claim within six months of the <i>life-changing event</i> which causes you to claim.	
We do not receive the medical evidence we need from your General Practitioner and any specialists who are treating you.	Provision C4.7
We are not satisfied that the <i>serious illness</i> that has led to your claim occurred either while we were providing you with Education Cover or was disclosed to us when you applied.	
Your Education Cover expires before the <i>life-changing event</i> which leads to your claim.	Your <i>plan schedule</i>

### How your Education Cover continues after a claim for serious illness cover

When we have accepted a *serious illness* cover claim for Education cover no further premiums will be payable for Education Cover. Education Cover will also be removed for any other person covered on the *plan*.

### Maximum benefit amounts

For claims as a result of a *serious illness*, the maximum combined Education Cover, Family Income Cover, Disability Cover and Serious Illness Cover *benefit* we will pay for a person covered over the life of the *plan* is £2,000,000.

If you reach this maximum *benefit* amount, we will not accept any further *serious illness* claims for Education Cover and Family Income Cover. Disability Cover and Serious Illness Cover will be removed from your *plan*. If we do that, we will reduce your premiums accordingly.

## C4.9 How your Education Cover premiums change each year

Your premium for Education Cover may change at each *plan anniversary*. The change will reflect any change in education costs. We will not look at *your* individual circumstances but at the change in education costs to everyone we insure.

Each year we will assess the change in the cost of education by considering:

- changes in private school fees
- changes in university tuition fees
- changes in school expenses with reference to the *Retail Prices Index*.

We will not review *your* premium with reference to:

- *your* individual health circumstances
- *our* claims experience, or the experience of the whole insurance industry, and
- the potential future costs to *us* of settling claims.

Before each *plan anniversary* we will send *you* an updated schedule showing *your* new premium for Education Cover.

Any change in *your* Education Cover premium could affect other covers in *your plan*. For more about this, see provision D1.

## C5. Waiver of Premium on Incapacity

Waiver of Premium on Incapacity means that if *you* become incapacitated, we stop charging the *plan premium* for *your plan*.

- If *you* have a *single life plan*, *you* can choose to add this cover.
- If *you* have a *joint life plan*, *you* can choose to add this cover for just one person covered, or both people can have it separately.

*Your plan schedule* shows if *your plan* includes this cover. *You* can add or remove this cover at any time. If *you* apply to add it, we will *underwrite your* request.

### C5.1 When we will waive your premiums

We will waive *your plan premium* if *you* become ill, injured, or disabled, and *your* incapacity meets one of the following definitions:

A standard definition means that illness or injury makes *you* unable to perform the material and substantial duties of *your own occupation*. These are the duties that are normally needed to do *your own occupation* and that cannot reasonably be omitted or modified by *you* or *your* employer. To meet this definition, *you* must also not be working in any other *occupation* for payment or profit.

An *activities of daily living* definition means that we assess *your* incapacity according to a specific set of everyday physical activities. These are designed to help show how able someone is to look after themselves. We list these activities in provision D5.4. We use this definition to assess *houseperson* claims, see provision C5.6.

A special definition means that illness or injury makes *you* unable to follow *your own occupation* or any other *occupation* to which *you* are suited by qualifications, education or experience. If there is a suited *occupation* that *you* could perform despite *your* illness or injury, we will not waive *your plan premium*. This is irrespective of whether *you* do that *occupation* or not.

We offer people different definitions depending on whether they are in paid work and what kind of work they do. *Your plan schedule* shows which definition applies to *you* if it is not the standard definition.

**When we will start waiving your plan premium**

We will start waiving *your plan premium* on the day after *your deferred period* ends.

The *deferred period* starts on the date you become incapacitated according to the definition that applies to *your plan*. It ends when you have been continuously incapacitated for one of:

- seven days (this is only an option if you are *self-employed*)
- one month
- three months
- six months, or
- twelve months.

You choose *your deferred period* when you set up this cover. If you have a *joint life plan*, each person covered can choose their own *deferred period*. For some own *occupations* you cannot choose a *deferred period* of seven days or one month. We will tell you if this applies to you.

*Your plan schedule* shows which *deferred period* applies to your Waiver of Premium on Incapacity.

**Telling us that you want to claim**

If you become incapacitated and need to claim, you need to give us written notice within a specified period of time. This notification period depends on the *deferred period* you have chosen. If you have a *deferred period* of:

- seven days, you should notify us immediately,
- one month, your notification period is two weeks,
- three, six or twelve months, your notification period is two months.

If we don't receive notice of *your* incapacity within the specified period, we may treat the *deferred period* as if it started on the date we actually receive notice.

If we receive notice more than 90 days after the end of the *deferred period*, we may decline *your* claim.

**Providing us with evidence for your claim**

We will need to be satisfied that *your claim* is valid in order to waive *your plan premium*.

When you first make *your claim*, we will ask for evidence to substantiate it. This evidence may include, but is not limited to:

- A report from *your* General Practitioner.
- Copies of *your* medical records.
- A report from any other *appropriate medical specialist*.
- *Your* hospital records, including copies of the results of any clinical tests or investigations.
- Information from *your* employer, including details of the duties of *your employment*.
- *Your* human resources records, including details of sickness absence.

We may also need you to have a medical examination with an examiner that we choose, at *our* expense. We may appoint a disability counsellor or someone who represents us to talk to you about any aspect of *your* claim.

At reasonable intervals we may also ask you to fill in a claim form, to confirm that you are still entitled to Waiver of Premium on Incapacity.

If you do not give consent for us to access *your* medical information, or to get any other assistance or information that we need to assess *your* claim, then we may decline, suspend, or stop paying you any *benefits* under Waiver of Premium on Incapacity Cover.

**C5.2 How long we will waive your plan premium for****When we will start waiving your plan premium**

We will start waiving *your plan premium* on the day after *your deferred period* ends. For more about the *deferred periods*, see provision C5.1.

### When we stop waiving your plan premium

We will continue to waive *your plan premium* until the first of the following occurs:

- You become able to start work in *your own occupation* again. We will base this on *your* ability to work, not the availability of work.
- You are no longer suffering any loss of income from *your own occupation*, despite *your* illness or injury.
- You perform any kind of work for profit or reward.
- You unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of *your* illness or injury.
- For Health Cover premiums, the first anniversary following the end of the *deferred period*.
- You fail to provide us with satisfactory proof that you are entitled to the *benefit* within 30 days of us asking for it, or you do not have a physical examination and medical tests – at our expense – when we ask.
- You fail to provide us with satisfactory proof that *your* incapacity is ongoing when we ask for it. We might need this so we can confirm that you continue to be entitled to the *benefit*.
- Your Waiver of Premium on Incapacity reaches its *date of expiry*. Your *plan schedule* shows the *date of expiry* for this cover.
- You are removed from the *plan*.
- The *plan* is cancelled.
- Your death.

### C5.3 Which plan premium increases we will waive

While we are waiving *your plan premium*, we will waive any increases that happen because:

- you have an indexed *plan account*,
- *your plan premium* increases as a result of Accelerator, or
- we review *your plan premium*.

While we are waiving *your plan premium*, you will have to pay any increases that happen because:

- you add more covers to *your plan*, or
- you increase the amount of any of *your* covers.

### C5.4 When we will not waive your plan premium

We will not waive *your plan premium* if the *life-changing event* which causes *your* claim occurs after the *date of expiry* for this cover.

### C5.5 What happens if you need to claim again

If you recover and return to work but then need to make another claim under this cover, we will waive the *deferred period* for this subsequent claim. This waiver only applies if the subsequent claim is:

- caused by the same *life-changing event* as the original claim, and
- within three months of the original waiver of premium ending.

### C5.6 What happens if you are not in employment when you make a claim

#### If you are unemployed or on a career break

If you become *unemployed* – or take a *career break* – and claim under Waiver of Premium on Incapacity Cover within a month of leaving work, we will assess *your* claim against *your* previous *own occupation*.

If you claim more than one month after leaving work, we will assess you as a *houseperson*. We may also change the *deferred period* that applies to *your* Waiver of Premium on Incapacity Cover. For more about the *deferred period* for Waiver of Premium on Incapacity Cover, see provision C5.1.

**Houseperson claims**

We will use the *houseperson* category to assess claims for anyone who is:

- a *houseperson*
- a student
- retired
- working less than 16 hours a week, or
- *unemployed* – and has been for at least one month.

**When we will accept your claim**

If *you* become ill or injured to the extent that *you* cannot perform three out of the six *activities of daily living*, we will accept *your* claim. For more about *activities of daily living*, see provision D5.4. *You* will not need to give us details of *your* earnings when *you* claim.

**How long we will pay for**

We will stop waiving *your* premiums under the *houseperson* category if:

- *you* start work in any *employment* or *occupation* for profit or reward, or
- *you* no longer fail three out of the six *activities of daily living*.

**C5.7 What happens if you start to earn an income**

If *you* start or return to work for profit or reward *you* need to tell us immediately. If *you* don't do this, we may:

- stop waiving *your* plan premium, or
- cancel *your* plan.

**C5.8 What happens if you change your occupation**

*You* do not need to tell us if *you* change *your* occupation while *you* are covered under *your* plan. We will assess any claims *you* make according to the *occupation* *you* were in immediately before *you* claimed.

If we would not normally use an *own* occupation definition for that *occupation*, then we may use *activities of daily living* to assess *your* claim. For more about *activities of daily living* assessments, see provision D5.4.

**C6. Waiver of Premium on Serious Illness**

Waiver of Premium on Serious Illness means that if *you* get a *serious illness* that we class as severity A, we stop charging the *plan* premium for *your* plan.

*You* do not need to have Serious Illness Cover to have this waiver. However, unless *you* have the Minimum Protected Account option, *you* cannot add this waiver to *your* plan if *you*:

- only have Serious Illness Cover, at 100% of *your* plan account, or
- only have Life Cover plus Serious Illness Cover at 100% of *your* plan account.

This is because plans set up as above and without the Minimum Protected Account option will end if *you* get a severity A Serious Illness Cover payment – so there will be no *plan* premium left to waive.

If *you* have a *joint life plan*, *you* can choose to add this cover for just one person covered, or both people can have it separately. *You* can add or remove this cover at any time. If *you* apply for this cover, we will *underwrite* *your* request.

*Your* plan schedule shows if *your* plan includes this cover.

## C6.1 When we will waive your plan premium

We will waive all further *plan premiums* if *your* claim meets all of the following criteria:

- *You* are diagnosed with a *serious illness* that meets *our* definition and which is classed as severity level A. For more about the illnesses we cover, see Appendix 1.
- We receive written notice of *your* claim within six months of the *life-changing event* that caused the claim.
- *Your* GP and any relevant specialist treating *you* give *us* any medical evidence we ask for.
- *You* survive for at least 14 days from the date of the *life-changing event*. We may waive this condition under some circumstances.
- If *your* claim is in the permanent disability category, *you* survive to the date when we agree that *you* are totally and *permanently* disabled.

## C6.2 When we will start waiving your plan premium

We will start waiving *your plan premium* 15 days from the date of the *life-changing event* that caused *your* claim. However, if *your* claim is under the permanent disability category, we will start waiving *your plan premium* when we agree that *you* are totally and *permanently* disabled.

## C6.3 Which premium increases we will waive

While we are waiving *your plan premium*, we will waive any increases that happen because:

- *you* have an indexed *plan account*,
- *your plan premium* increases as a result of Accelerator, or
- we review *your* premiums.

While we are waiving *your plan premium*, *you* will have to pay any increases that happen because:

- *you* add more covers to *your plan*, or
- *you* increase the amount of any of *your* covers.

## C6.4 When we will stop waiving your plan premium

We will stop waiving *your plan premium* when any of the following events happen:

- *Your* Waiver of Premium on Serious Illness reaches its *date of expiry*.
- All the covers that we are waiving the premiums for reach their dates of expiry.
- For Health Cover premiums, the first anniversary following the date *you* become eligible for the *benefit* for Waiver of Premium on Serious Illness.
- *You* are removed from the *plan*.
- The *plan* is cancelled.
- *Your* death.

## C7. Waiver of Premium on Death

This cover is only available if *you* have a *joint life plan*.

### C7.1 When we will waive your plan premium

Waiver of Premium on Death means that if one person covered dies or is diagnosed with a *terminal illness*, we stop charging *plan premiums* for the other person covered by *your plan*. *You* can include this cover for either or both people covered.

*Your plan schedule* shows if *your plan* includes this cover and who is covered for Waiver of Premium on Death.

### C7.2 When we will start waiving your plan premium

We will start waiving *your plan premiums* from the date the person covered dies, or the date of the diagnosis of a *terminal illness*. However, we will not waive *your plan premiums* if:

- this date is after the *date of expiry* of the Waiver of Premium on Death, or
- the claim is due to a *terminal illness* that is diagnosed less than 12 months from the *date of expiry* of the Waiver of Premium on Death.

### C7.3 Which premium increases we will waive

While we are waiving *your plan premiums*, we will waive any increases that happen because:

- *you* have an indexed *plan account*,
- *your plan premium* increases as a result of Accelerator, or
- we review *your* premiums.

While we are waiving premiums, *you* will have to pay any increases that happen because:

- *you* add covers to *your plan*, or
- *you* increase the amount of *your* cover.

### C7.4 When we will stop waiving your plan premium

We will stop waiving *your plan premiums* when any of the following events happen:

- The Waiver of Premium on Death reaches its *date of expiry*.
- All the covers that we are waiving the premiums for reach their *dates of expiry*.
- For Health Cover premiums, the first anniversary following the date *you* become eligible for the *benefit* for Waiver of Premium on Death.
- The *plan* is cancelled.
- The death of the remaining person covered.

## C8. The Minimum Protected Account option

The Minimum Protected Account option is available for single and *joint life plans*.

If *you* make a successful claim under Serious Illness Cover or Optional Serious Illness Cover for Children, the Minimum Protected Account option tops up *your plan account* to a minimum level. *You* choose this minimum level when *you* add this option to *your plan*.

*You* can apply to add the Minimum Protected Account option to *your plan* if *you* have at least one of:

- Serious Illness Cover
- Optional Serious Illness Cover for Children

*You* can apply to add this option to *your plan* at any time. We will *underwrite your request*. *You* can remove this cover from *your plan* at any time.

*Your plan schedule* shows if *your plan* includes the Minimum Protected Account option.

### C8.1 How the Minimum Protected Account option works

When *you* add the Minimum Protected Account option to *your plan*, *you* choose how much of *your plan account* *you* want to protect. This amount must be between 25% and 100% of the value of *your plan account* at the time.

- If *you* have a level *plan account*, the amount of the Minimum Protected Account option will stay the same for the life of *your plan*.
- If *you* have a decreasing or indexed *plan account*, the amount of the Minimum Protected Account option will decrease or increase at the same rate as the covers in *your plan account*.

If we pay you a *benefit* under Serious Illness Cover or Optional Serious Illness Cover for Children, *your plan account* will reduce by the amount of that *benefit*. If it reduces to below the amount that *you* have protected using the Minimum Protected Account option, we will top it back up to that amount. We do this as soon as we have paid all the *benefits* that are due as a result of *your* claim.

### **C8.2 When the Minimum Protected Account option ends**

If *your plan* no longer has either Serious Illness Cover or Optional Serious Illness Cover for Children, we will remove the Minimum Protected Account option from *your plan*. As a result, we will reduce the premium for *your plan*. For more about how *your* Serious Illness Cover may end, see provision B2.

### **C9. Protected Life Cover**

If *you* have Serious Illness Cover as well as Life Cover, *you* have the option to include Protected Life Cover in *your plan*. This means that *your* Life Cover will not reduce if *you* claim under Serious Illness Cover or Optional Serious Illness Cover for Children.

## D. Managing your plan

### D1. Paying your plan premium

*Your plan premium is made up of the individual premiums for each of the covers in your plan. Your plan schedule shows the details of your premium.*

*You pay your plan premium monthly, in advance, by direct debit.*

The premiums for any waiver of premium covers and Unemployment Cover depend on the premiums you pay for the other covers you have in your plan.

If you have the Minimum Protected Account option, the individual premium for this will depend on the amount of Life Cover, Serious Illness Cover and Optional Serious Illness Cover for Children you have.

#### D1.1 What happens if you do not pay your plan premium

If you do not pay your monthly plan premium by the due date, we will suspend all the covers in your plan. However, you can ask us to reinstate your plan within thirteen months of the date of the first unpaid plan premium as long as:

- You pay all of the outstanding plan premiums. If your plan premium would have increased in the time that you have not been paying it, you will need to pay the increased amounts.
- You provide us with a new direct debit instruction so we can collect future plan premiums.
- You and any other person covered by the plan completes a reinstatement application form. This is so that we can underwrite your request. We may offer you revised terms, or decline your request. We will not ask for evidence for any children covered by the plan. However, if your plan is reinstated, we will not pay any child's claim for a condition that was pre-existing at the time of reinstatement.

#### D1.2 When your premiums end

*Your plan schedule shows the date of expiry of each of your covers. It also shows whether your premium will increase automatically. The date of expiry will be different for each person covered by the plan.*

*We will collect your final premium for each cover on the last due date before the date of expiry.*

#### D1.3 Indexed premium increases

If the benefits for any of your covers are indexed, we will increase your premiums annually. We will increase them by the total of:

- the percentage rise in the *Retail Prices Index*, from a minimum of 0% to a maximum of 10%, and
- 2.5%.

If the *Retail Prices Index* is not suitable, we will use another index that measures retail price inflation.

We will increase indexed premiums on each anniversary of your plan. We will send you a new plan schedule 30 days before the increase is due to take effect. The plan schedule will show you how much the premiums are going to increase by.

You do not have to accept the increase to your premiums. However, if you do not want to accept them, you need to notify us before the date that the increases are due to take effect. You can also ask us not to apply indexation in any year. If you do this for three consecutive years for any individual cover, we will cancel the indexation for that cover.

If we have cancelled indexation, you can apply for us to re-introduce it. However, we will need to repeat the underwriting process for all the people covered.

If you have Unemployment Cover, please see the separate plan provisions for that cover for details of how it is affected by indexation.

## D1.4 Accelerator

If *your plan schedule* shows you have chosen Accelerator your premiums will increase at each *plan anniversary* for each of the following covers:

- Life Cover
- Serious Illness Cover
- Income Protection Cover
- Optional Serious Illness Cover for Children
- Disability cover
- Minimum Protected Account

The premium for each cover will increase by 3% on either:

- Each *plan anniversary* for the first ten *plan anniversaries*, or
- each *plan anniversary* until the *date of expiry*.

*Your plan schedule* will show which option applies to *your plan*.

For some premiums, any change following an increase in premium due to Accelerator could affect other covers in *your plan*. For more about this, see provision D1.

## D1.5 How making a claim affects your premiums

Your premiums may be affected if you make a claim.

For *single life plans*, your premiums will stay the same after you have made a claim, except:

- When the cover ends after a claim. In this case, you will no longer have to pay the premium for that cover.
- When you make a claim for Optional Serious Illness Cover for Children, and you have neither the Minimum Protected Account option nor Protected Life Cover. In this case, we will reduce your premium by the same proportion as the reduction in *your plan account*. We will reduce the premium for everyone covered by the *plan* except the *child* that the claim was made for.

For *joint life plans*, we will reduce your premium if you make a claim for Serious Illness Cover or Optional Serious Illness Cover for Children and you have neither the Minimum Protected Account option nor Protected Life Cover. We do this because the claim reduces the amount of the *plan account*. We reduce the premium in proportion to the reduction in the *plan account*. We will reduce the premium for everyone covered by the *plan* except the person who claimed.

We will allow your *plan premium* to fall below our normal minimum *plan premium* if the reduction is because of a claim.

## D1.6 How Vitality affects your plan premiums

Your *plan premium* may change as a result of Premium Saver. We will apply the change on your *plan anniversary* in addition to any other changes that are due. We apply any changes as a result of Premium Saver after any changes that result from indexation or Accelerator.

We will tell you if your premium is going to change at least 30 days before your *plan anniversary*.

For more about how Premium Saver works, see provision E2.1.

## D1.7 Enforced changes in premiums

We will govern and interpret your *plan* according to the applicable taxation, laws and regulations of England and Wales. Whether you have guaranteed premiums (see provision D2) or reviewable premiums (see provision D3), if taxation changes or if we are otherwise required to change your premiums under these laws and regulations we will make this change as soon as it is necessary to do so and we will write to tell you. Where an increase in premiums is necessary, it will be limited to the amount necessary to cover the increase in cost to us of providing cover.

## D2. Guaranteed premiums

A guaranteed premium is one that will only change as a result of choices that *you* make. Without this option, we would review *your* premiums regularly and potentially change them. For more about reviewable premiums, see provision D3.

If *you* have a:

- *whole of life plan account* with Serious Illness Cover *you* cannot guarantee *your* premiums,
- *fixed term for your plan account* or a *whole of life plan account* with no Serious Illness Cover, *you* can choose to have guaranteed premiums for Disability Cover and any of the covers in *your plan account*.

*You* can also have a guaranteed premium for Family Income Cover and Income Protection Cover. However, *you* need to choose this option separately.

*Your plan schedule* shows whether any of *your* covers have guaranteed premiums.

If *you* choose guaranteed premiums, we work out *your* premiums by making assumptions that cover the full duration of the *plan*.

Even if *you* choose guaranteed premiums, the amount *you* pay will not necessarily stay the same for the duration of the *plan*. *Your* premiums could change:

- if *you* change *your plan*,
- if *you* make a claim,
- depending on Premium Saver
- if *your* premiums are indexed, or
- if *you* have chosen Accelerator, see provision D1.4.

## D3. Reviewable premiums

We will review *your* premiums periodically if *your plan schedule* shows that any of *your* covers have reviewable premiums.

### D3.1 How we review your premiums

When we review *your* premiums, we do not look at *your* individual circumstances such as *your* health. We look at the premiums we are charging to everyone we insure.

We will look at:

- *our* claims experience, and the experience of the whole insurance industry,
- medical trends and advances, including treatments and diagnostic techniques that could affect *our* claims experience for any of the covers that we provide,
- the potential future costs to *us* of settling claims, and
- changes in applicable law or taxation.

A review will affect each type of cover in *your plan* separately. It will apply to the full amount for each cover in *your plan*, including any changes *you* have made to *your* cover since *you* set *your plan* up. The date for each review will be based on the *start date* of the cover for each person covered, even if *you* have made later additions to the cover.

For some premiums, any change following a review could affect other covers in *your plan*. For more about this, see provision D1.

If *your* premium changes because of Premium Saver (see Provision E2) or *you* have chosen Accelerator this does not count as a review.

Premium reviews for Unemployment Cover and Health Cover work differently. For more about these, see their separate plan provisions.

### D3.2 Reviewing premiums for a whole of life plan account

Unless *your plan schedule* shows that *you* have guaranteed premium rates we will review *your* premiums for each of the covers in *your whole of life plan account* on the tenth anniversary of that cover. We may then review them every year. However, if we change one of *your* premiums as a result of a review, we will not review that premium again for another ten years. The exceptions to this are:

- For Serious Illness Cover, we will also review the premium on the 70<sup>th</sup> birthday of each person covered. Even if we change the premium, we will then review it each subsequent year.
- For Life Cover, we will also review the premium on the 75<sup>th</sup> birthday of each person covered. Even if we change the premium, we will review it each subsequent year.

If *you* have a *joint life plan*, we will review the premiums for each person covered separately.

There is no limit on the amount we might increase or reduce *your* premium by after a review.

### D3.3 Reviewing premiums for a fixed term plan account, Disability Cover, Family Income Cover and Income Protection Cover

If *you* did not choose guaranteed premiums on a *fixed term plan account*, Disability Cover, Family Income Cover or Income Protection Cover, we will review *your* premiums on the fifth anniversary of *your plan*. We may then review them every year.

However, if we change one of *your* premiums as a result of a review, we will not review that premium again for another five years. If *you* have a *joint life plan*, we will review the premiums for each person covered separately.

There is no limit on the amount *your* premium could increase or reduce by after a review.

### D3.4 Telling you if your premium needs to change

If *your* premium needs to change as a result of a review, we will tell *you* at least 30 days before the date the change is due to take effect. We will also explain *your* options.

### D3.5 Your options if your premium needs to change as the result of a review

This table shows *your* options if *your* premium needs to change as the result of a review.

If your premium needs to:	You can choose to:	What you need to do:
Increase	Accept the increased premium.	<i>You</i> do not need to do anything.
	Keep <i>your</i> current premium and have less cover.	Tell <i>us</i> in writing within 30 days of receiving <i>our</i> notification. If <i>your</i> current premium is below <i>our</i> allowable minimum, we will ask <i>you</i> to increase <i>your</i> premium to the minimum level.
	Cancel <i>your</i> cover.	For how to cancel a cover, see provision F.
Decrease	Accept the decreased premium.	<i>You</i> do not need to do anything.
	Ask to keep <i>your</i> current premium and have more cover.	Apply to <i>us</i> in writing within 30 days of receiving <i>our</i> notification. We may need to <i>underwrite</i> <i>your</i> request.
	Cancel <i>your</i> cover.	For how to cancel a cover, see provision F.

## D4. Changing your covers

There are several ways *you* can change *your* covers. *You* can:

- add or increase covers
- remove or reduce covers
- remove a person covered from a *joint life plan*
- split a *joint life plan* into two *single life plans*
- change the *fixed term* of *your* covers
- change *your deferred period*
- lower *your* premiums because of a change in *your* circumstances
- remove Accelerator.

We explain below when and how *you* can make these changes.

If *you* want to make a change, *you* need to make it on the same day of the month as the *start date* of *your plan*. If *your plan* is suspended, *you* cannot make any changes to it.

### D4.1 Adding or increasing covers

*You* can apply to add covers to *your plan*, or increase *your* existing levels of cover, at any time – subject to the restrictions explained below. We will increase *your* premium based on the increase in cover and the age of the person covered at the time the change is made.

Any addition or increase *you* make will be subject to *our* terms and conditions when *you* make the change.

#### Restrictions on adding or increasing covers

- *You* cannot make an addition or increase if it would be beyond the limits that apply to *your plan*.
- We may subject *your* request for an addition or increase to *underwriting*.
- *You* cannot add or increase covers if *you* are resident outside the *United Kingdom*.
- *You* cannot add Life Cover if Serious Illness Cover is the only cover in *your plan account*. For joint life plans, *you* also cannot add Life Cover if we have previously paid *you* a claim for Life Cover.
- *You* cannot increase *your* Income Protection Cover or Family Income Cover while we are paying *you* a *benefit* under that cover.
- If *your plan premiums* are being waived at the time *you* ask to add or increase covers, *you* will need to pay the premium for the increased amount.

### D4.2 Removing or reducing covers

*You* can apply to remove covers from *your plan*, or reduce *your* existing levels of cover, at any time. *You* can do this as long as *you* leave at least one of the following covers in *your plan*:

- Life Cover
- Serious Illness Cover
- Income Protection Cover

We will reduce *your* premium to take into account:

- What it would have been if *you* had the reduced cover when that cover started.
- Any premium reviews we have carried out.
- Any Accelerator premium increases.
- Premium Saver

Reducing a cover might also reduce other covers in *your plan*. *Your* premiums might also change. For more about this, see provision D1.

If *your plan premium* drops below the minimum *plan premium* we allow, we may ask *you* to maintain it at a higher level. If this happens, *you* will receive a level of cover that reflects that higher premium.

### D4.3 Removing a person covered from a joint life plan

If you have a *joint life plan*, you can remove either of the people covered from it. If you do, the *plan* will continue as a *single life plan* for the remaining person covered, as long as that person has at least one of the following covers:

- Life Cover
- Serious Illness Cover
- Income Protection Cover

If the remaining person has:

- Life Cover, this will set the amount of the *plan account*. Their Serious Illness Cover cannot be higher than this amount.
- Serious Illness Cover but no Life Cover, this will set the amount of the *plan account*.
- Neither Life Cover nor Serious Illness Cover, they will not have a *plan account*.

When we remove a person from *your plan*, we will remove all the covers from the *plan* that apply to that person. We will recalculate the premium payable as the amount that would have applied if the *plan* had originally been taken out as a *single life plan*, adjusted for any premium reviews or changes in premium as a result of Premium Saver, Accelerator premium increases or indexation premium increases.

If your new *plan premium* drops below the minimum *plan premium* we allow, we may ask you to maintain it at a higher level. If this happens, you will receive a level of cover that reflects that higher *plan premium*.

We will also:

- Remove any Waiver of Premium on Death.
- Remove any Waiver of Premium on Serious Illness if the only remaining covers are Life Cover and Serious Illness Cover at 100%, or just Serious Illness Cover at 100%.
- Reduce any remaining Optional Serious Illness Cover for Children so that it does not exceed the total amount in the *plan account*.
- Adjust the Minimum Protected Account option, if you have it, so that it reflects the new value of the *plan account*.
- Remove the Minimum Protected Account option altogether if Life Cover is the only cover left in the *plan account*.

### D4.4 Splitting a joint life plan into two single life plans

You can split a *joint life plan* into two separate *single life plans*. The new plans can have the same covers, levels of cover and term as the existing *joint life plan*.

We will adjust the *plan premium* for each *plan*, to take into account:

- What it would have been if you had taken out a *single life plan* when your *plan* started.
- Any premium reviews we have carried out.
- Any Accelerator premium increases.
- Premium Saver.
- Any premium increases as a result of indexation.

If neither person wants to add to or increase a cover or increase the *date of expiry* they had under the original *plan*, we will not need any additional medical evidence.

If either person's new *plan premium* drops below the minimum *plan premium* we allow, we may ask them to maintain it at a higher level. If we do, they will receive a level of cover that reflects that higher *plan premium*.

We will also:

- Remove any Waiver of Premium on Death.
- Remove any Waiver of Premium on Serious Illness if the remaining covers are Life Cover and Serious Illness Cover at 100%, or just Serious Illness Cover at 100%.
- Reduce any remaining Optional Serious Illness Cover for Children so that it does not exceed the total amount in the *plan account*.

- Adjust the Minimum Protected Account option, if *you* have it, so that it reflects the new value of the *plan account*.
- Remove the Minimum Protected Account option altogether if Life Cover is the only cover left in the *plan account*.

We will include any remaining Optional Serious Illness Cover for Children in the *plan account* of whoever was the *first person covered* in the original *plan*. If *you* would like *us* to include it in the other person's *plan account*, or would like *us* to split it evenly between the two *plan accounts*, *you* will need to write to *us*. The maximum cover under Optional Serious Illness Cover for Children for any one *child* across all plans held with *us* is £100,000.

The two new *plans* will be subject to all the provisions that applied to the original *plan*.

#### **D4.5 Changing the fixed term of your covers**

*You* can change the *fixed term* of *your covers* at any time, as long as *your new plan premium* does not drop below *our* minimum allowable *plan premium*. If *you* have a decreasing *plan account*, *you* cannot change the term of individual covers within it; all the covers must have the same term.

If *you* reduce a *fixed term*, *your new plan premium* will be the same as or less than the one *you* are currently paying.

If *you* want to increase a *fixed term*, we will need to *underwrite your* request. *Your* new premium will be calculated using the rates applicable at the time of the change.

If a *fixed term* cover pays a lump sum, *you* cannot extend the *fixed term* beyond the *date of expiry* of *your plan account*.

If *you* make a change to certain covers, other covers in *your plan* could be affected. For more about this, see provision D1.

#### **Changing your deferred period**

*You* can change *your deferred period* for any cover that has one, except Disability Cover.

If *you* increase *your deferred period*, *your* new premium will be the same as or less than the one *you* are currently paying. If *you* want to decrease *your deferred period*, we will need to *underwrite your* request.

#### **D4.6 Lowering your premiums because of a change in your circumstances**

If a change in *your* circumstances could lead to a lower premium, it is in *your* interest to tell *us*. We will then offer *you* a new premium, as long as:

- *you* complete a declaration of health form, if we ask *you* to, that confirms *you* are in good health, and
- the new premium is lower than *your* current one.

Examples of changes in circumstances that we will consider are giving up smoking or stopping hazardous activities.

#### **D4.7 Removing Accelerator**

If *your plan schedule* shows that *you* have chosen Accelerator, *you* can apply to remove this option at any time.

If *you* want to keep *your* premium at the same level until the *date of expiry*, the level of cover will be reduced. When *you* apply to do this we will calculate the new level of cover for each of the covers in *your plan*. For more about the covers which are affected by Accelerator, please see provision D1.4.

If *you* want to keep *your benefit* at the same level until the *date of expiry*, the premium will increase for each of the covers to which Accelerator applies. When *you* apply to do this we will calculate the premium for each of the covers in *your plan*. For more about the covers which are affected by Accelerator, please see provision D1.4.

For some premiums, any change following an increase in premium due to the removal of Accelerator could affect other covers in *your plan*. For more about this, see provision D1.

## D5. Claiming a benefit

This provision explains:

- how and when *you* can claim a *benefit* under *your plan*,
- who we will pay the *benefit* to,
- the exclusions to claiming a *benefit*.

### D5.1 Who we will pay the benefit to

We will pay the *benefit* to the person legally entitled to receive it.

### D5.2 Telling us about a claim

If a claim needs to be made under *your cover*, we need *you* to tell *us* as soon as possible. We describe the exact notification requirements for each type of cover in the individual cover sections of these plan provisions.

### D5.3 What we need before we can settle a claim

For a Life Cover claim or Family Income Cover claim, we will need proof that the person covered has died. If *your plan* is arranged on a *joint life second death* basis we will need proof that both people covered have died. We may also need proof of the age(s) of the person(s) covered, if we have not already received it.

For any claim under either Optional Serious Illness Cover for Children or Education Cover, we will need to see a birth certificate. We may also need proof of *your* relationship to the *child* if their birth certificate does not provide this.

For each type of cover, we describe what we need before we can settle a claim in the individual cover sections of these plan provisions.

If *your plan* has been placed in trust, we will require a copy of the original trust deed. Please ensure that the trustees keep this in a safe place.

### D5.4 Confirming that you are incapacitated

For some types of cover, we may need to assess whether *you* are incapacitated. To make this assessment, we will need an *appropriate medical specialist* to confirm that *you* have an ongoing inability to perform a series of *functional activity tests* without the help of another person or an appropriate device. We explain these tests below. The individual cover sections in these provisions will explain which tests are relevant to a claim under that cover. There are two types of *functional activity tests*:

- *activities of daily living*, and
- *activities of daily work*.

#### Types of functional activity tests

Activities of daily living	How we define this activity
Continence	The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained.
Dressing	The ability to put on, take off, secure and unfasten all garments and any braces, artificial limbs or other surgical appliances.
Feeding	The ability to feed oneself once food and drink have been prepared and made available.
Mobility	The ability to move from one room to another in <i>your</i> normal place of residence on the same floor, using any walking stick or frame, if required.
Transferring	The ability to move from a bed to an upright chair or wheelchair, and vice versa.
Washing	The ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained.

Activities of daily work	How we define this activity
Walking	The ability to walk 200 metres on a level surface with a stick or other aid without stopping or severe discomfort.
Lifting	The ability to pick up a 1kg object from table height with either hand and carry it for 5 metres.
Using a pen, pencil or keyboard	The ability to use a pen, pencil or keyboard with either hand using any reasonable aids.
Hearing	The ability to hear well enough, with hearing aids, to understand someone speaking in a common language in a normal voice in a quiet room.
Speech	The ability to be understood in a common language in a quiet room.
Vision	The ability to see well enough to read 16 point print using spectacles or other reasonable aids.

### Knowing which tests are relevant to your claim

If when you make your claim you are:

- Aged 65 or over, we will assess your claim based on whether you can perform a series of *activities of daily living*. However, if you are making a claim under Income Protection or any waiver of premium, we will use *activities of daily work* to assess your claim instead.
- Aged between 16 and 65, we will assess your claim based on whether you can perform *activities of daily work* or *activities of daily living*. After you have taken the tests, we will use the results that are most favourable to you to assess whether you are incapacitated.

If you are a houseperson, we will always use the *activities of daily living* to assess your claim. For more about houseperson claims, see provision B3.5.

The specific tests you need to take will depend on the cover you are claiming under. We explain which test or tests you will need to take in the individual cover sections of these provisions.

For any claim, your inability to perform a particular activity needs to have been caused by a condition that arose after the *start date of your plan*.

### D5.5 Making a claim when you are abroad

If you are outside the *United Kingdom*, the Channel Islands or the Isle of Man when you make a claim for anything other than Life Cover, we will need an *appropriate medical specialist* to confirm all your information and your diagnosis. We will consider information from *appropriate medical specialists* in *permitted countries*.

### D5.6 Exclusions

#### General exclusions

If the illness, condition or procedure you are claiming for is a consequence of an excluded condition, we will not pay any *benefit* under any of these covers:

- Serious Illness Cover
- Family Income Cover (payable on diagnosis of a *serious illness*)
- Education Cover (payable on diagnosis of a *Severity A serious illness*)
- Education Cover (Serious Illness Cover for Children)

- Optional Serious Illness Cover for Children
- Disability Cover
- Income Protection Cover
- Waiver of Premium on Serious Illness
- Waiver of Premium on Incapacity

This applies to the excluded conditions in the definitions of named conditions or any exclusions that were included in *your* acceptance terms at the start of the *plan*.

For some covers we will not pay any *benefits* if *your* claim arises, either directly or indirectly, because *you* unreasonably do not seek or follow medical advice. These covers are:

- Serious Illness Cover
- Family Income Cover (payable on diagnosis of a *serious illness*)
- Education Cover (payable on diagnosis of a Severity A *serious illness*)
- Education Cover (Serious Illness Cover for Children)
- Optional Serious Illness Cover for Children
- Disability Cover
- Waiver of Premium on Serious Illness
- Waiver of Premium on Incapacity

#### **Exclusions for Life Cover, Family Income Cover and Education Cover**

##### **Exclusions for suicide**

We will not pay a claim for Life Cover, Family Income Cover or Education Cover if one of the people covered dies as a result of suicide within 12 months of:

- the *start date* of the Life Cover, Family Income Cover or Education Cover,
- the date they were added to the *plan*,
- the date the *plan* was re-instated if it was suspended because *your plan premiums* were not paid.

If *you* have increased the Life Cover or Family Income Cover under *your plan*, and one of the people covered dies as a result of suicide within 12 months of the increase, we will not normally pay the additional amount as part of the claim.

##### **Exclusions for Serious Illness Cover, Family Income Cover (payable on diagnosis of a serious illness) and Education Cover (payable on diagnosis of a severity A serious illness)**

Appendix 1 explains the exclusions that apply to claims for specific illnesses under Serious Illness Cover or Family Income Cover (payable on diagnosis of a *serious illness*) or Education Cover (payable on diagnosis of a severity A *serious illness*).

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 1. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

We may have excluded specific conditions from *your* Serious Illness Cover, Family Income Cover or Education Cover. If we have, and *you* make a claim for another *body system category*, we will not pay a *benefit* if our Chief Medical Officer believes that the illness is a direct result of the conditions that we have declined or excluded.

We will only accept a claim if the condition *you* are claiming for occurred after the *start date* of *your plan*, or *you* disclosed it to *us* when *you* applied for cover.

##### **Exclusions for Optional Serious Illness Cover for Children and Education Cover (Serious Illness Cover for Children)**

Appendix 1 explains the exclusions that apply to claims for specific illnesses under Optional Serious Illness Cover for Children and Education Cover (Serious Illness Cover for Children).

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 1. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

#### Exclusions for Disability Cover

Appendix 2 explains the exclusions that apply to Disability Cover claims. These exclusions apply even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

We may have excluded specific conditions from *your* Disability Cover. If we have, and *you* make a claim for another *body system category*, we will not pay a *benefit* if *our* Chief Medical Officer believes that the illness is a direct result of the conditions that we have declined or excluded.

We will only accept a claim if the condition *you* are claiming for occurred after the *start date* of *your plan*, or *you* disclosed it to *us* when *you* applied for cover.

If the person making the claim is:

- *Permanently* based outside the *permitted countries*, we will not pay any *benefit* under Category C Disability Cover.
- *Temporarily* based outside the *permitted countries*, we will only pay a maximum of three consecutive *benefit* payments for Disability Cover.

#### Exclusions under Waiver of Premium on Incapacity

If the person making the claim is temporarily based outside the *permitted countries*, we will only waive a maximum of 12 months' *plan premiums* for Waiver of Premium on Incapacity.

#### Exclusions under Waiver of Premium on Death

We will not waive a *plan premium* under Waiver of Premium on Death if one of the people covered dies, as a result of suicide, within 12 months of:

- the *start date* of the cover for that person, or
- the date the *plan* was re-instated if it was suspended because *your plan premiums* were not paid.

## D6. How a joint life first death plan continues if one person dies

If one of the people covered on a *joint life first death plan* dies we will remove all the covers that apply to the person who has died from the *plan*.

The *plan* will continue for the surviving person as described below.

### D6.1 How the premiums change

For the surviving person covered, we will recalculate their *plan premium*:

- Based on what they would have been if *you* had originally applied for a *single life plan* instead of a *joint life plan*.
- Using their age, the term and the premium rates that applied when any covers were added or changed.
- Allowing for:
  - any premium reviews of *your joint life plan*
  - any changes *you* made to *your joint life plan*
  - Premium Saver
  - any annual changes to *your premium* as a result of Accelerator or indexation.

If the new *plan premium* drops below the minimum *plan premium* we allow, we may ask the surviving person to maintain it at a higher level. If that happens, the surviving person will receive a level of cover that reflects that higher *plan premium*.

If the person who died had Waiver of Premium on Death, we will stop charging premiums for the surviving person. For more about Waiver of Premium on Death, see provision C7.

## D6.2 How the covers change

For the surviving person covered, the following covers will continue without any changes to the *benefit*:

- Disability Cover
- Income Protection Cover
- Unemployment Cover

However, we will:

- Remove Life Cover, Family Income Cover or Education Cover for the remaining person if we have made a Life Cover payment, including for a *terminal illness*.
- Reduce any remaining Optional Serious Illness Cover for Children so that it does not exceed the amount of any remaining Serious Illness Cover.
- Remove Optional Serious Illness Cover for Children if it is the only *benefit* left in the *plan account*.
- Remove the Minimum Protected Account option if there is no Serious Illness Cover or Optional Serious Illness Cover for Children left in the *plan account*.
- Remove any Waiver of Premium on Death.
- Remove Waiver of Premium on Serious Illness if Serious Illness Cover is the only cover remaining.

If the surviving person wants to increase their cover, we will need to *underwrite* their request.

If the surviving person wants further Life Cover, Family Income Cover or Education Cover they will need to set up a new *plan*. We will base any new Life Cover, Family Income Cover or Education Cover on the age of the person and the premium rates that apply when they set up the new *plan*. We may also need to subject the request to limited *underwriting*. The premium for any new Life Cover, Family Income Cover or Education Cover will not be covered by any Waiver of Premium on Death.

## D7. How a joint life second death plan continues if one person dies

If one of the people covered on a *joint life second death plan* dies the policy will continue and the *plan premium* will continue at the same level. If the person who died had Waiver of Premium on Death, we will stop charging *plan premiums*. For more about Waiver of Premium on Death, see provision C7.

## E. Vitality

*Your plan* includes *Vitality*, our proven wellness programme which includes activities and partner discounts to help you get and stay healthy for less. All adults covered by the *plan* are eligible for the *Vitality* programme. However, *children* are not.

By completing *Vitality* activities, you will be able to contribute to improving your *Vitality status*.

### E1. The Vitality commitment

We will keep the *Vitality* programme available for the duration of *your plan*. As this could be many years, we will revise both the *Vitality* programme and *Vitality* partners from time to time.

Our *Vitality* programme naturally changes 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 or eligible activities in the *Vitality* programme 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 of the *Vitality* programme, 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 to the programme. *Vitality* 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.

In most cases changes to *Vitality* will be made at *plan anniversary*, but in some circumstances the *Vitality* programme may change at any time.

We will usually tell you about any changes to the *Vitality* programme, 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 are not satisfied with the changes we make to the *Vitality* programme, you may cancel your *plan* in accordance with the information in provision F2.

If you would like full details of the *Vitality* programme that is in effect at any time, you can call us on 0845 601 0072.

### E2. How Vitality affects your premiums

#### E2.1. Premium Saver

*Your plan* includes Premium Saver.

With Premium Saver, we could reduce your premiums for certain periods during the term of your *plan*. How much we reduce your premiums will depend on:

- which covers you have in your *plan*;
- whether each cover is indexed, level or decreasing; and
- what your *Vitality status* is at each *plan anniversary*.

When we calculate any premium reductions that you are entitled to under the Premium Saver, we will use the premium for the following covers:

- Life Cover
- Serious Illness Cover
- Income Protection Cover
- Optional Serious Illness Cover for Children
- Disability Cover
- Family Income Cover

- Education Cover
- Waiver of Premium on Incapacity
- Waiver of Premium on Death
- Waiver of Premium on Serious Illness
- Minimum Protected Account

### E2.1.1 How we calculate your premium reduction

The total premium reduction *you* will receive will build up over each five-year period. The first period will begin on *your plan* start date (or if *you* added Premium Saver after *your plan* start date, the date of the *plan anniversary* on which *you* added Premium Saver).

At *your plan* anniversary, for each cover, we will multiply the premiums which *you* have paid us in the previous year for that cover by the relevant percentage in the table below. The percentage is based on *your* Vitality status at the *plan anniversary* and whether the cover is indexed or not.

Vitality status at plan anniversary	Cover not Indexed	Cover Indexed
Platinum	15%	20%
Gold	10%	15%
Silver	7.5%	12.5%
Bronze	0%	10%

We will add this to the amount that *you* have built up in previous years during the five-year period. At the beginning of each subsequent five-year period we will reset the amount that *you* have built up to zero.

### E2.1.2 How we reduce your premiums

At the fifth *plan anniversary* (or if *you* added Premium Saver after *your plan* start date, the fifth *plan anniversary* after *you* added Premium Saver), and every five years after that, we will use the amount that *you* have built up to calculate how much we will reduce *your* premiums by for the next two years.

The amount we reduce *your plan* premiums by will depend on whether *you* pay *your* premiums to us monthly or annually.

#### If you pay your premiums monthly

We will calculate the amount by which *your* premium will reduce by dividing the amount *you* have built up in the previous five years by 24. We will then deduct this amount from the *plan premium* which would normally be payable each month. This reduction will apply for the next 24 months. The amount of the premium reduction cannot be greater than the amount of the monthly *plan premium* due.

#### If you pay your premiums annually

We will calculate the amount of *your* premium reduction by dividing the amount *you* have built up in the previous five years by two. We will then deduct this amount from the *plan premium* which would normally be payable each year. This reduction will apply for the next two years. The amount of the premium reduction cannot be greater than the amount of the annual *plan premium* due.

Whether *you* pay premiums monthly or annually, after 24 months *your* premium reduction will stop and *you* will then need to pay us the full *plan premium*. The statement sent to *you* on *your plan anniversary* will show *your plan premium* without the reduction from the Premium Saver.

### **E2.1.3 How to find out if any of your benefits are indexed**

Your plan schedule will show whether any of *your* covers are indexed. Education Cover is automatically indexed. If any *benefits* in *your plan* are indexed, the premiums payable in respect of Waiver of Premium on Incapacity, Waiver of Premium on Death and Waiver of Premium on Serious Illness are also indexed.

If one of *your* benefits is indexed, but *you* decide that *you* do not want it to increase at a particular *plan anniversary*, then in that year we will apply the non-indexed percentage for that *benefit* instead. The non-indexed percentages are shown in E2.1.1

### **E2.1.4 What happens when your premiums are being waived**

If we are waiving *your* premiums under Waiver of Premium on Incapacity, Waiver of Premium on Death, Waiver of Premium on Serious Illness or Unemployment Cover (see Unemployment Cover Plan Provisions) we will use the premiums that *you* would otherwise have paid *us* to calculate *your* premium reduction for Premium Saver.

Also, if, while we are waiving *your* premiums, *you* would have been entitled to a premium reduction, we will defer the premium reduction until *you* start to pay *your* premiums again. At this time we will reduce *your* premiums by the amount of the premium reduction. We will reduce *your* premium for a maximum of 24 months.

### **E2.1.5 How your future premium reduction builds up while your premiums are being reduced**

When we calculate the amount that builds up for the five-year period, we will use the premium that *you* would have paid *us* had we not applied the premium reduction for Premium Saver.

### **E2.1.6 What happens at the end of your plan term**

At the end of *your plan* term, *you* can use the amount that *you* have built up to reduce the premiums on a new *plan* from PruProtect.

If *you* pay *your* premiums monthly, the monthly premium reduction will be calculated by dividing the amount that has been built up by 24. The monthly premium reduction will be limited to 50% of the full monthly premium for the new *plan*. It will apply for a maximum of 24 months.

If *you* pay *your* premiums annually, the annual premium reduction will be calculated by dividing the amount that has been built up by two. The annual premium reduction will be limited to 50% of the full annual premium for the new *plan*. It will apply for a maximum of two years.

Any new *plan* must be taken out within three months of the old *plan*. If *you* do not take out a new *plan* within three months of the old *plan* ending then *you* will lose *your* entitlement to any Premium Saver *you* have built up.

*Your* new *plan* will be subject to *our* new business terms and conditions and rates at the time *you* take it out. To work out what we can cover *you* for and how much *your* premiums will be, we will need to ask *you* for more information about *your* health and lifestyle when *you* take out *your* new *plan*.

### **E2.1.7 What happens if you cancel your plan before the end of your plan term**

*You* will lose *your* entitlement to any Premium Saver. Premium Saver does not have any cash value.

## F. General terms and conditions

### F1. When your plan ends

Your plan will end when the first of the following occurs:

- The death of the person covered in a *single life plan*, or the death of one person covered in a *joint life first death plan* (see provision D6), or both persons covered in a *joint life second death plan* (see provision D7).
- Your plan account reduces to zero after a claim, and you also do not have the Minimum Protected Account option, or any Disability Cover, Income Protection Cover or Unemployment Cover as part of your plan at that time.
- All covers under your plan have reached their *date of expiry*.

### F2. Cancelling your plan

#### When you may cancel your plan

You can cancel your plan at any time.

If you cancel it within 30 days of receiving your plan details, we will refund your plan premiums, as long as you have not made a claim. To do this, please contact us by post at:

PruProtect  
Stirling  
FK9 4UE

Or by phone on: 0845 601 0072

If you cancel your plan after 30 days, we will not refund your plan premiums. You can either contact us to cancel it, or just cancel your direct debit.

#### When we may cancel your plan

##### Fraud

We may cancel your plan if you:

- make any untrue statements to us,
- fail to disclose any material facts relevant to your plan or a claim, or
- act fraudulently in any other way.

If we cancel your plan because of fraud, your plan will become void. If this happens, we will return all the plan premiums you have paid.

##### Other reasons

The Financial Services Authority (FSA) publishes a Conduct of Business Sourcebook that sets out the rules to do with when it is reasonable for a company to cancel a plan like this one. We will apply these rules to your plan. We will apply these rules to the plan as a whole, rather than to each type of cover separately.

The FSA may update their rules during the life of your plan. For the latest rules, please contact the FSA at [consumer.queries@fsa.gov.uk](mailto:consumer.queries@fsa.gov.uk) or by phoning 0845 606 1234. You can also download the Conduct of Business Sourcebook at [www.fsa.gov.uk](http://www.fsa.gov.uk)

### F3. Cash value

Your plan does not have any cash value.

### F4. Mis-statement of age

If any person covered under the plan did not state their age accurately when they applied, we will change the terms of the plan in a way that we consider to be just and reasonable.

## F5. Assignment

If *you* assign any of *your* legal rights under the *plan* to someone else, including changing who is entitled to the *plan*, *you* need to give *us* written notice. Please do this by writing to: The Prudential Assurance Company Limited, Stirling, FK9 4UE.

We will not change who is entitled to *benefits* under *your plan* until we receive this notice.

## F6. Currency

All payments we make to *you* and all payments made to *us* must be in the lawful currency of the *United Kingdom*.

## F7. Complaints

If *you* have a complaint, please talk to *your* financial adviser first. If they cannot help, or if *you* set up *your plan* directly with *us*, please contact *us* by post at:

PruProtect,  
Stirling,  
FK9 4UE

Or by phone on: 0845 601 0072

To help *us* improve *our* service, we may monitor or record *your* call.

To help *us* deal with *your* complaint as quickly as we can, please have *your plan* number to hand when *you* call or write to *us*.

If we cannot resolve *your* complaint satisfactorily, *you* can refer it to the Financial Ombudsman Service. *You* can contact them by post at:

South Quay Plaza,  
183 Marsh Wall,  
London,  
E14 9SR

Or by phone on: 0800 023 4567

Making a complaint will not affect *your* legal rights.

## F8. If we cannot meet our obligations

We are covered by the Financial Services Compensation Scheme. This means that *you* may be entitled to financial help up to 90% of the value of *your* loss if we cannot meet *our* obligations.

For more information about the Financial Services Compensation Scheme, please contact them by email: [enquiries@fscs.org.uk](mailto:enquiries@fscs.org.uk) or by phone: 0800 678 1100.

## F9. Law

We will govern and interpret *your plan* according to the applicable laws and regulations of England and Wales. Where we are required to change *your plan* under these laws and regulations we will do so. *Your plan* will be subject to the exclusive jurisdiction of the English courts.

Anyone who is not party to this contract has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce any of the terms of this *plan*. We include the *planholder* and any other person covered as party to the *plan*.

## F10. Data Protection Notice

We think it's important for all *our* customers to be made aware of what information PruProtect as part of the PruHealth Group\* holds about them and to reassure *our* customers that we comply with the Data Protection Act 1998.

### How we use your personal information

PruProtect will use *your* personal information (including information provided about *your* dependants) to underwrite, administer, profile *your* purchase preference and service *your* Plan. By taking out a Plan with us, *you* consent to us using *your* personal information and sensitive personal information (e.g. health information). We will also use *your* information for statistical data analysis, management information and fraud prevention purposes.

### Who we may give personal information to

We may disclose *your* personal information to other companies in the PruHealth Group, *our* business associates, agents or service providers for the purposes above. *Your* information may be used by service providers in a country outside the European Economic Area, which may not have the same standard of data protection as in the UK. We will ensure appropriate safeguards are in place to protect *your* information.

We will pass *your* personal information and information about *your* Plan to any legal or regulatory body if required to do so. We may also use *your* information or give it to others, for research, statistical purposes or to improve *our* services, but we will remove *your* name and address from this first. We may send copies of correspondence relating to *your* Plan to *your* Financial Adviser, if you've appointed one. We may provide information about a claim to them, although no medical information will be provided without *your* consent.

When giving us information about another person, *you* confirm that they have appointed *you* to act on their behalf. This includes providing consent to process the personal information, receive this Data Protection Notice on their behalf and unless *you* decide otherwise, receive marketing information.

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

### Our marketing policy

PruProtect, PruHealth's group of companies and *our* business associates, service providers and agents may use *your* personal information to inform *you* of other services and products that may be of interest to *you* by telephone, post, email or text. Please call *our* Customer Services Team if *you* would prefer not to receive details of other products.

### Obtaining a copy of the information we hold about you

*You* have the right to request a copy of the information we hold about *you* or someone *you* act on behalf of (for which we may charge a fee) and to have any inaccurate information corrected by writing to the Data Protection Co-ordinator at the below address

PruHealth / PruProtect  
Marshall Point  
4 Richmond Gardens  
Bournemouth  
BH1 1JD

### Disposal of information

We will continue to hold information about *you* and *your* Plan for a reasonable period of time after it has ended. We will then dispose of *your* personal information in a responsible way to maintain *your* confidentiality.

### Changing this Data Protection Notice

This Data Protection Notice may change from time to time and *you* should review the contents regularly. We will notify *you* of any changes where we are required to do so by law.

\* PruHealth is a joint venture between Prudential in the UK and Discovery Holdings Limited in South Africa. The PruHealth Group includes Prudential Health Limited and Prudential Health Insurance Limited, both trading as PruHealth, and Prudential Health Services Limited trading as PruHealth and/or PruProtect.

## G. Definitions

### Acceptance letter

The letter we send *you* when we accept the application for a *plan* that names *you* as a person covered. This letter includes the terms of the *plan*, and any special conditions.

### Activities of daily living

A specific set of everyday physical or functional activities that help to show how able someone is to look after themselves. We may refer to these activities if *you* make a claim to do with incapacity. We list these activities in provision D5.4. We also call these activities *functional activity tests*.

### Activities of daily work

A specific set of everyday physical or functional activities that help to show how able someone is to work. We may refer to these activities if *you* make a claim to do with incapacity. We list these activities in provision D5.4. We also call these activities *functional activity tests*.

### Alcohol or drug abuse

Inappropriate use of alcohol or drugs, including but not limited to:

- Drinking too much alcohol.
- Taking controlled drugs as defined by the Misuse of Drugs Act 1971, unless they are legally prescribed.
- Taking an overdose of drugs, whether legally prescribed or not.

### Appropriate medical specialist

Someone who is:

- A medical consultant or equivalent at a hospital in the *United Kingdom* or any of the *permitted countries*.
- A specialist appropriate to the cause of the claim.
- Registered in the *United Kingdom* or in any of the *permitted countries*.
- Not related by blood or *marriage* to the person or people covered, and
- Accepted by *our* Chief Medical Officer.

### Benefit

Money we pay to *you* if *you* make a successful claim under the *plan*.

### Body system category

The category of *serious illnesses* that affect a particular body system, as outlined in Appendix 1.

### Career break

A specific period that *you* take away from *your own occupation*, after which *you* intend to return to the same position.

### Child/children

A person who:

- Is at least three months old.
- Has not reached the first *plan anniversary* after their 18th birthday.
- Is *your* natural child, adopted child or step-child, and
- Is looked after by, or financially dependent on, *you*.

### Confirmed expenditure

This is the expenditure we will take into account when determining the Spend Protector Benefit which we will pay *you* in the event of a claim. We reserve the right to ask for documentary evidence at the time of *your* claim to enable us to calculate the amount of Spend Protector Benefit that we will pay *you*.

Documentary evidence includes, but is not limited to:

- Copies of bills for regular household expenditure.
- 3 months bank statements covering the period immediately before *your* claim.

If we have not received documentary evidence we will calculate the confirmed expenditure with reference to the most recent edition of the Family Spending survey, published by the Office for National Statistics.

### Current benefit amount

The current benefit amount is the amount on which we would base any payments for a successful claim.

The current benefit amount can change over time. It can change because *you* have chosen an *indexed account* or a *decreasing account*. It can also change because *you* have made a successful claim or because *you* have asked us to change *your plan*.

The current benefit amount will be shown on the most recent *plan schedule*, servicing schedule or anniversary letter.

### Date of expiry

The date a cover ends. The date of expiry of each of *your covers* is shown on the *plan schedule*.

### Decreasing account

A *plan account* that decreases in value over the life of the *plan*. It decreases in the same way as a repayment mortgage that has a 7% annual equivalent interest rate. If the *plan* is *fixed term*, *you* can choose to have a decreasing account. If *you* have Disability Cover, *you* can also choose for it to decrease in this way.

**Acceptance letter**

The letter we send you when we accept the application for a *plan* that names you as a person covered. This letter includes the terms of the *plan*, and any special conditions.

**Activities of daily living**

A specific set of everyday physical or functional activities that help to show how able someone is to look after themselves. We may refer to these activities if you make a claim to do with incapacity. We list these activities in provision D5.4. We also call these activities *functional activity tests*.

**Activities of daily work**

A specific set of everyday physical or functional activities that help to show how able someone is to work. We may refer to these activities if you make a claim to do with incapacity. We list these activities in provision D5.4. We also call these activities *functional activity tests*.

**Alcohol or drug abuse**

Inappropriate use of alcohol or drugs, including but not limited to:

- Drinking too much alcohol.
- Taking controlled drugs as defined by the Misuse of Drugs Act 1971, unless they are legally prescribed.
- Taking an overdose of drugs, whether legally prescribed or not.

**Appropriate medical specialist**

Someone who is:

- A medical consultant or equivalent at a hospital in the *United Kingdom* or any of the *permitted countries*.
- A specialist appropriate to the cause of the claim.
- Registered in the *United Kingdom* or in any of the *permitted countries*.
- Not related by blood or *marriage* to the person or people covered, and
- Accepted by our Chief Medical Officer.

**Benefit**

Money we pay to you if you make a successful claim under the *plan*.

**Body system category**

The category of *serious illnesses* that affect a particular body system, as outlined in Appendix 1.

**Career break**

A specific period that you take away from your own *occupation*, after which you intend to return to the same position.

**Child/children**

A person who:

- Is at least three months old.
- Has not reached the first *plan anniversary* after their 18th birthday.

- Is your natural child, adopted child or step-child, and
- Is looked after by, or financially dependent on, you.

**Confirmed expenditure**

This is the expenditure we will take into account when determining the Spend Protector Benefit which we will pay you in the event of a claim. We reserve the right to ask for documentary evidence at the time of your claim to enable us to calculate the amount of Spend Protector Benefit that we will pay you.

Documentary evidence includes, but is not limited to:

- Copies of bills for regular household expenditure.
- 3 months bank statements covering the period immediately before your claim.

If we have not received documentary evidence we will calculate the confirmed expenditure with reference to the most recent edition of the Family Spending survey, published by the Office for National Statistics.

**Current benefit amount**

The current benefit amount is the amount on which we would base any payments for a successful claim.

The current benefit amount can change over time. It can change because you have chosen an *indexed account* or a *decreasing account*. It can also change because you have made a successful claim or because you have asked us to change your *plan*.

The current benefit amount will be shown on the most recent *plan schedule*, servicing schedule or anniversary letter.

**Date of expiry**

The date a cover ends. The date of expiry of each of your covers is shown on the *plan schedule*.

**Decreasing account**

A *plan account* that decreases in value over the life of the *plan*. It decreases in the same way as a repayment mortgage that has a 7% annual equivalent interest rate. If the *plan* is *fixed term*, you can choose to have a decreasing account. If you have Disability Cover, you can also choose for it to decrease in this way.

**Deferred period**

The time between becoming incapacitated and when we start paying a *benefit*.

**Employed/Employment**

Paid work under a contract of employment and paying Class 1 National Insurance contributions.

**First person covered**

For a *single life plan*, this is the insured person. For a *joint life plan*, this is the insured person with the highest amount of Life Cover when the *plan* starts. If there is no Life Cover in the *plan*, then it is the

insured person with the highest amount of Serious Illness Cover or Income Protection Cover when the *plan* starts. If the amounts of these covers are the same for both people, the first person covered is the first person named on the application form.

#### Fixed term

The term of a cover is how long the cover lasts. A fixed term has a defined *date of expiry*.

#### Functional activity tests

Specific sets of everyday physical or functional activities that help to show how able someone might be to work or look after themselves. The two kinds of tests are called *activities of daily work* and *activities of daily living*. We may refer to these activities if you make a claim to do with incapacity.

#### Full-time occupation

An *occupation* that normally takes up at least 16 hours a week on a regular basis.

#### Houseperson

A person who has a *full-time occupation* maintaining the home or caring for one or more dependants.

#### Indexed account

A *plan account* that is designed to increase in value on each *plan anniversary*. The increase is a percentage of the current *plan account*. This percentage will be equal to the *Retail Prices Index* that applies exactly five months before the *plan anniversary*, subject to a maximum of 10% and a minimum of 0%.

If you have Disability Cover or Income Protection Cover or Family Income Cover, you can also choose for any of these covers to increase in this way.

#### Irreversible

Cannot be reasonably improved by medical treatment and/or surgical procedures used by the National Health Service in the *United Kingdom* at the time of the claim.

#### Joint life plan

A *plan* that provides cover for two people. We call these two people the *first person covered* and the *second person covered*.

#### Joint life first death

Life Cover where we pay the *benefit* when the first of the persons covered dies or is diagnosed with a *terminal illness*.

#### Joint life second death

Life Cover where we pay the *benefit* when the last of the persons covered dies or is diagnosed with a *terminal illness*.

#### Level account

A *plan account* that stays the same unless you make a successful claim or change a cover. If you have Disability Cover or Income Protection Cover, you can also choose one or both of these covers to stay level in this way.

#### Life-changing event

A single identifiable event or condition that causes you to make a claim.

#### Maximum monthly benefit amount

- Income Protection Cover, or
- Income Protection Cover and Category C Disability Cover combined.

The actual amount depends on whether you have Primary or Comprehensive Income Protection Cover. There is more about this in provision B3.2.

#### Non-invasive

A description of malignant or cancerous cells that have not spread into surrounding healthy cells or tissue.

#### Optimal therapy

Therapy that is currently recommended by:

- The National Institute for Clinical Excellence,
- NHS Prodigy Guidelines, or
- British (or European) Cardiac or Hypertension Societies.

#### Occupation

A trade, profession or type of work undertaken for profit or pay. It is not a specific job with any particular employer and is independent of location.

#### Own occupation

The *full-time occupation* you had immediately before the start of the illness or injury (or incapacity for the purposes of Income Protection Cover).

#### Permanent/Permanently

Expected to last throughout your life and not expected to improve, irrespective of when the cover ends or you are due to retire.

#### Permanent Neurological Deficit With Persisting Clinical Symptoms

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout your life. Symptoms that are covered include:

- numbness
- hyperaesthesia (increased sensitivity)
- paralysis
- localised weakness
- dysarthria (difficulty with speech)
- aphasia (inability to speak)

- dysphagia (difficulty in swallowing)
- visual impairment
- difficulty in walking
- lack of coordination
- tremor
- seizures
- lethargy
- dementia
- delirium
- coma.

The following are not covered:

- an abnormality seen on brain or other scans without definite related clinical symptoms
- neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- symptoms of psychological or psychiatric origin.

#### Permitted Countries

Andorra, Australia, Austria, Belgium, Canada, Channel Islands, Denmark, Finland, France, Germany, Gibraltar, Greece, Isle of Man, Italy, Liechtenstein, Luxembourg, Malta, Monaco, The Netherlands, New Zealand, Norway, Portugal, Republic of Ireland, San Marino, Spain, Sweden, Switzerland, *United Kingdom* and United States of America.

#### Plan

The PruProtect Essentials Plan.

#### Planholder

The owner of the *plan*.

#### Plan account

An amount that determines how much we can pay out if *you* make a claim under Life Cover, Serious Illness Cover or Optional Serious Illness Cover for Children. There are special rules for *simultaneous claims* under Serious Illness Cover. For more about this, see provisions B2.4 to B2.6.

#### Plan anniversary

The anniversary of the *start date* of the *plan*.

#### Plan premium

This is the total premium payable in respect of the covers in *your plan*. This does not include any explicit premium which we may charge for the *Vitality* programme.

#### Plan schedule

A document that shows:

- the cover or covers in the *plan*
- the amount of each cover
- the premium for each cover
- the *date of expiry* of each cover, unless the cover is *whole of life*
- any special conditions.

#### Pre-existing medical condition

A medical condition (whether or not a diagnosis was made or any symptoms were evident) which existed before any of these dates, as appropriate:

- The *start date* of the *plan*.
- The *start date* of the relevant cover.
- The relevant *child* reaching the age of three months (only for Optional Serious Illness Cover for Children and Education Cover (Serious Illness Cover for Children)).
- The legal *adoption* of the relevant *child* (only for Optional Serious Illness Cover for Children and Education Cover (Serious Illness Cover for Children)).
- The date that the *plan* is reinstated following non-payment of *plan premiums*.

#### Pre-incapacity earnings

This depends on whether *you* are *employed* or *self-employed*, as explained below:

##### If you are employed

Your average gross monthly earnings for PAYE purposes from *your own occupation* in the 12 months before the incapacity. This includes:

- Salary before any tax or national insurance contributions have been taken off.
- Regular commission or bonus payments.
- Regular overtime payments.
- P11D *benefits* in kind as long as these will be lost in the event of incapacity, and
- dividend income from this *employment* as long as:
  - it is paid directly to *you* in lieu of salary
  - it ceases in the event of incapacity
  - it is consistent with the salary, and
  - the company's trading position reasonably allows *you* to receive it on a continuing basis.

##### If you are self-employed

Your average gross monthly taxable earnings from *your business* in the 12 months before the incapacity. *You* can take off from this figure any amounts allowable as expenses against income tax. *You* must not take off from this figure any income tax or national insurance contributions.

When *you* work out *your* pre-incapacity earnings, do not include any of these:

- income from savings
- income from rental of property or goods
- dividends which are not included in the box above.

#### Pre-malignant

A description of abnormal or cancerous cells that might develop into a malignant tumour but have not yet done so.

#### Progressive claim

A second claim that happens in the following way:

1. A person covered has a *life-changing event* that causes a *serious illness*.
2. They make a first successful claim for that *serious illness*.
3. They later make a second claim which is for the same *serious illness* or another serious illness that was caused by the same *life-changing event*.
4. The two illnesses are in the same *body system category*. The *body system categories* are set out in Appendix 1.

#### Prudential

The Prudential Assurance Company Limited

#### Resident of the United Kingdom

A person who legally lives in the *United Kingdom* for at least 40 weeks in any 52 week period.

#### Retail Prices Index

The measure of *UK* inflation known as the Retail Prices Index (all items), as published by the Office for National Statistics. If the *UK* Government replaces that index with another index of *UK* retail price increases, we shall use that replacement index.

#### Reward

An offer we make to you from time to time that rewards you for achieving a *Vitality status* or helps you to engage with the *Vitality* programme.

The suppliers and prices of rewards will vary from time to time. We will tell you the terms and conditions of the rewards when we offer them.

#### Second person covered

If two people are insured on a *plan*, this is the insured person who is not the *first person covered*. This person cannot be a *child*.

#### Self-employed

- actively working alone, with others in a partnership, or as a member of a limited liability partnership, and
- paying Class 2 National Insurance contributions, and
- assessable for Income Tax under Schedule D Case I or II.

#### Serious illness

An illness or condition that:

- is defined in Appendix 1, and
- meets our criteria for that illness or condition.

The *serious illnesses* are divided into *body system categories*. These categories are set out in Appendix 1.

#### Simultaneous claims

Two or more *serious illness* claims that meet all of the following criteria:

- They are being made by more than one person covered or *child* under a *plan*.
- They are a result of the same life-changing event.
- They are within three calendar months of that *life-changing event*.

#### Single life plan

A *plan* that provides cover for one person only, referred to in this *plan* as the person covered. This does not include any cover provided for *children*.

#### Start date

The date when cover under the whole *plan* begins or, where relevant, when a particular cover begins.

#### Terminal illness

An advanced or rapidly progressing incurable illness where, in the opinion of an attending consultant and our Chief Medical Officer, life expectancy is no more than 12 months.

#### Underwrite/Underwriting

The process we use to assess your application to include or change a cover. *Underwriting* may lead us to:

- accept your application
- reject your application, or
- amend one or more terms.

#### Unemployed/Unemployment

Ceasing to follow your own *occupation* for more than one month, and not following any other *occupation*.

#### United Kingdom/UK

The United Kingdom of Great Britain and Northern Ireland. This excludes the Channel Islands and the Isle of Man.

#### Unrelated claim

A second claim that happens in the following way:

1. A person covered has a *life-changing event* that causes a *serious illness*.
2. They make a first claim for that *serious illness*.
3. They later make a second claim for another *serious illness* that was caused by a different *life-changing event*.

The two illnesses can be in the same *body system category*, or different *body system categories*, as defined in Appendix 1.

**UK university**

Any tertiary education institution which offers a recognised *UK* qualification that meets the criteria listed in provision C4.2.

**Verified earnings**

A figure for *your* earnings that we verify when *you* make *your* application for Income Protection Cover or, where appropriate, for an increase to this cover. *You* may need to provide *us* with evidence of these earnings. There is more information about this in provision B3.1.

**Vitality**

*Our* health and wellbeing programme. *You* can earn points and *rewards* in the programme and progress through status levels. *Rewards* are separate from this *plan*, and have their own terms and conditions.

**Vitality status**

A measure of *your* achievement in *our* *Vitality* programme. There are four status levels: Bronze, Silver, Gold and Platinum. *Your* *Vitality* status depends on the recorded efforts that *you* make in the programme between each *plan anniversary*.

**We/Us/Our**

The Prudential Assurance Company Limited

**Whole of life**

The term of a cover that lasts from the covers *start date* to the death of the insured person for *joint life first death* or the death of both persons covered for *joint life second death*.

**You/Your**

The person named on the *plan schedule* as the person covered. For a *joint life plan*, either or both people covered, as appropriate.

# 1 Appendix

## Illnesses and Conditions – Definitions for Serious Illness Cover (see provision B2).

This *plan* follows the ABI Statement of Best Practice for Critical Illness Cover (April 2006). All model illness definitions are included and the amount we pay *you* ranges from 25% to 100% depending upon their severity. However, some conditions at a lower level of severity may qualify for an increased payment if, or when, their severity increases.

Cancer is included at a minimum severity of 25%, although higher staged tumours may qualify for an increased payment. The ABI model wording has been used however for the purpose of this *plan* we also provide cover for low grade prostate cancers that have a Gleason score of between 2 and 6 inclusive or a TNM classification of T1N0M0. The complete list of ABI model definitions is set out below.

These headings are only a guide to what is covered. The full definitions of the illnesses covered and the circumstances in which *you* can claim are given in this Appendix. These definitions typically use medical terms to describe the illnesses and severities and how they are measured. In some cases the cover may be limited, for example some types of cancer are not covered and to make a claim for some illnesses, *you* need to have *permanent* symptoms.

- Alzheimer's disease  
– resulting in *permanent* symptoms
- Aorta graft surgery  
– for disease
- Benign brain tumour  
– resulting in *permanent* symptoms
- Blindness  
– *permanent* and *irreversible*
- Cancer  
– excluding less advanced cases
- Coma  
– resulting in *permanent* symptoms
- Coronary artery by-pass grafts  
– with surgery to divide the breastbone
- Deafness  
– *permanent* and *irreversible*
- Heart attack  
– of specified severity
- Heart valve replacement or repair  
– with surgery to divide the breastbone
- HIV infection  
– caught in the *UK* from a blood transfusion, a physical or sexual assault or at work in an eligible *occupation*\*

- Kidney failure  
– requiring dialysis
- Loss of hands or feet  
– *permanent* physical severance
- Loss of speech  
– *permanent* and *irreversible*
- Major organ transplant
- Motor neurone disease  
– resulting in *permanent* symptoms
- Multiple sclerosis  
– with persisting symptoms
- Paralysis of limbs  
– total and *irreversible*
- Parkinson's disease  
– resulting in *permanent* symptoms
- Stroke  
– resulting in *permanent* symptoms
- Third degree burns  
– covering 20% of the body's surface area
- Traumatic head injury  
– resulting in *permanent* symptoms

\* The eligible *occupations* for HIV caught at work are listed in provision 1 h) i of this Appendix.

## 1.a Cancer category – specified conditions of defined severity

### 1 DEFINITIONS

#### Advanced Aplastic anaemia

Aplastic anaemia is the reduction of circulating red cells, white cells and platelets. For the purposes of this *plan* pancytopenia, causing a reduction to 10% of the normal number of white cells and platelets as well as 50% of the normal levels of red cells, must be present. All lines of blood production must be depressed as demonstrated by bone marrow examination and abnormalities persisting on blood tests for a minimum of three months.

#### Advanced Cancer

An advanced malignant tumour that has progressed to at least Group Stage II of the TNM Classification of Malignant Tumours as described in the 6th edition of the International Union against Cancer (pub.Wiley-Liss).

#### Advanced Chronic Lymphocytic Leukaemia

For the purpose of this *plan* leukaemia means a disease of a single clone-line of white blood cells. There must be widespread uncontrolled growth of malignant white blood cells. There must also be evidence of replacement of the normal bone marrow by abnormal white cells with immature blast cells in the peripheral blood. Chronic Lymphocytic Leukaemia is covered when it has progressed to Binet Stage C.

#### Advanced Hodgkin's Disease

This is an advanced malignant condition of the reticulo-endothelial system, which includes the lymph nodes, spleen and liver characterised by Reed-Sternberg cells in the abnormal lymph tissue. The staging must have progressed to at least Stage II of the Ann-Arbor system.

#### Advanced Non-Hodgkin's Lymphoma

This is an advanced malignant condition of the reticulo-endothelial system, which includes the lymph nodes, spleen and liver. The staging must have progressed to at least Stage II of the Ann-Arbor system.

#### Cancer

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

The term malignant tumour includes leukaemia, lymphoma and sarcoma. For the above definition, the following are not covered:

- All cancers which are histologically classified as any of the following:
  - *pre-malignant*;
  - *non-invasive*;
  - cancer in situ;
  - having either borderline malignancy; or
  - having low malignant potential.

- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

#### Carcinoma in-situ of the Oesophagus requiring surgery

A definite diagnosis, which has been supported by histological evidence, of carcinoma in-situ of the oesophagus which has been treated surgically by removal of a portion, or all of the oesophagus.

#### Low Grade Prostate Cancer

Low-Grade Prostate Cancer means any malignant tumour of the prostate characterised by uncontrolled growth and spread of malignant cells and invasion of tissue which is histologically classified as having a Gleason score of between 2 and 6 inclusive or having progressed to a TNM classification of T1N0M0.

#### Lumpectomy for Ductal Carcinoma in-situ of the Breast

The undergoing of a lumpectomy, cystectomy or partial mastectomy for the removal of a tumour in one breast which has been histologically classified as Ductal Carcinoma in-situ (DCIS).

#### Marrow Aplasia

The reduction of circulating red cells, white cells or platelets causing a reduction to 25% of the normal number of one cell line of the red cells, white cells or platelets as well as 75% of the normal levels of red cells, must be present. The line of blood production must be depressed as demonstrated by bone marrow examination and abnormalities persisting on blood tests for a minimum of six months.

#### Mastectomy for Carcinoma in-situ of the Breast

Total removal of all the tissue of one breast for the treatment of carcinoma in-situ in the removed breast. Prophylactic mastectomy without histological evidence of cancer in-situ is not covered. We only cover mastectomy, any other surgical procedures such as lumpectomy and partial mastectomy are also excluded.

#### Multiple Myeloma

A malignant proliferation of plasma cells in the bone marrow with destruction of surrounding tissue on bone marrow examination. It must also cause a high level of abnormal proteins in the blood called paraproteinaemia demonstrated on protein electrophoresis. Monoclonal gammopathy of unknown significance will be excluded.

#### Myelodysplasia

Myelodysplasia is a clonal disorder of at least one cell line of the bone marrow causing insufficient number of normal blood cells.

## 2 SEVERITY LEVELS

### How is severity measured?

The severity level determines the payment(s) we make. The severity of cancer is measured by staging at diagnosis, so the higher the stage at diagnosis the higher the initial *benefit*. If a cancer progresses, we will assess the progression of the cancer using the same staging criteria as will be used at diagnosis.

For example, if *you* are diagnosed with stage 1 breast cancer, this is stage 1 disease at diagnosis. If this metastasises (spreads, or invades different organs or parts of the body) we will reclassify the staging, even if *your* medical records still state 'stage 1 but with metastases to the bones'. In this example we will reclassify the claim as stage 4. Please tell *us* if *you* believe that the cancer has spread to other organs or parts of the body, we will then liaise with *your* Oncologist and/or other specialist.

For the purpose of this *plan* we will assess the staging of cancer using The International Union against Cancer TNM Classification of Malignant Tumours 6th edition (Pub. Wiley-Liss). We will use the group stages 1–4 as defined within this reference book to allocate the severities.

**Leukaemia:** The severity of Chronic Lymphocytic Leukaemia is measured by the Binet classification which covers stages A to C.

**Hodgkin's Disease and non-Hodgkin's Lymphomas:** The severity is measured by staging and uses the Ann-Arbor system which covers stages I to IV.

**Myelodysplasia:** The severity is assessed using the International Scoring System for Prognosis in Evaluating Myelodysplasia syndromes as published by Greenberg et al, in the Journal 'Blood' 1997: 6; p 2079-2088. The prognostic score and details must be provided by the Consultant Haematologist supervising the monitoring or treatment of the patient. If no prognostic score is available *our* Chief Medical Officer will assess the most likely severity in conjunction with the Haematologist monitoring the patient.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

#### Severity Level A:

- Advanced cancer classified as a TNM Group Stage III tumour or above
- Advanced Hodgkin's Disease classified as Ann-Arbor Stage III or above
- Advanced Non-Hodgkin's Lymphoma classified Ann-Arbor Stage III or above
- Acute Myeloid Leukaemia
- Advanced Chronic Lymphocytic Leukaemia classified as Binet Stage C
- Chronic Myeloid Leukaemia
- Acute Lymphoblastic Leukaemia

- Advanced Aplastic Anaemia.

#### Severity Level C:

- Advanced cancer classified as a TNM Group Stage II tumour
- Advanced Hodgkin's Disease classified as Ann-Arbor Stage II
- Advanced Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage II
- Multiple Myeloma
- Myelodysplasia classified as Intermediate 1 under the International Prognostic Scoring System.

#### Severity Level D:

- Cancer
- Carcinoma in-situ of the Oesophagus requiring surgery
- Low-Grade Prostate Cancer
- Marrow Aplasia
- Mastectomy for Carcinoma in-situ of the Breast.

#### Severity Level E:

- Myelodysplasia classified as Low risk on the International Prognostic Scoring System as above

#### Severity Level F:

- Lumpectomy for Ductal Carcinoma in-situ of the Breast.

## 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Confirmation of the diagnosis by an *appropriate medical specialist* and copies of the specialist and hospital reports.
- Relevant CT/MRI scans, bone marrow histology and Full Blood Count results where appropriate.

## 4 SPECIFIC EXCLUSIONS

- All tumours which are histologically described as *pre-malignant*, as *non-invasive* or cancer in situ (other than those stated).
- Cervical, vaginal or prostatic intraepithelial neoplasia (dysplasia) with histology showing CIN-1 to CIN-3, VIN-1 to VIN-3 or PIN-1 to PIN-3, each inclusive.
- Lesions where there has been no invasion of tissue including, but not limited to, papillary micro-carcinoma of the thyroid or papillary cancer of the bladder histologically described as TisN0M0, TaN0M0 or of lesser classification.

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 1.b Heart and Artery category – specified conditions of defined severity

### 1 DEFINITIONS

#### **Angioplasty (Coronary) or PTCA (Percutaneous Transluminal Coronary Angioplasty)**

PTCA or other percutaneous coronary artery procedures performed by a Consultant Cardiologist to dilate and treat a coronary artery stenosis. The procedure may or may not involve the use of a stent.

#### **Angioplasty to correct Carotid Artery Stenosis**

Therapeutic angioplasty with or without stent to correct symptomatic stenosis of the carotid artery.

#### **Any Cardiac Condition resulting in a Reduced Ejection Fraction**

Any cardiac condition causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 39% or less. There must be two measurements with an interval of at least six months for a claim to be considered.

#### **Aorta Graft Surgery**

The undergoing of surgery for disease or traumatic injury to the aorta with excision and surgical replacement of a portion of the diseased or injured aorta with a graft.

The term aorta includes the thoracic and abdominal aorta but not its branches. For the above definition, the following are not covered:

- Any other surgical procedure, for example the insertion of stents or endovascular repair.

#### **Balloon Valvuloplasty**

The dilation of a stenotic valve of the heart by percutaneous balloon procedure performed by a Consultant Cardiologist.

#### **By-pass Graft Surgery to 3 or more Coronary Arteries**

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage to three or more coronary arteries with by-pass grafts.

#### **Cardiomyopathy resulting in a Reduced Ejection Fraction**

A disease of the heart muscle causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 39% or less. There must be two measurements with an interval of at least six months for a claim to be considered. Alcoholic cardiomyopathy is specifically excluded.

#### **Cardioversion for Cardiac Arrhythmia**

The intentional therapeutic medically supervised application of an electrical shock, using at least 40 joules, to correct a documented and recorded arrhythmia of the heart

#### **Congestive Heart Failure**

The inability of the heart muscle on either the right or left side of the heart, or both, to pump blood effectively resulting in a backflow into vessels supplying the heart. For the purposes of this *plan* this must be diagnosed by a Consultant Cardiologist and *optimal therapy* must have been established for at least 6 months. There must be at least 4 signs of congestive heart failure present for a claim to be considered.

The signs of congestive heart failure include:

- Presence of third heart sound
- Jugular venous pressure above 6 cms
- Rales present in both bases on auscultation
- Cardiomegaly on chest x-ray
- Grade 3, or gross ascites, associated with marked abdominal distension
- Severe oedema to a level above the knee.

#### **Coronary Artery By-pass Grafts**

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

#### **Emergency Intravenous Anti-arrhythmic therapy for Ventricular Tachycardia or Fibrillation**

Documented Ventricular Tachycardia or Ventricular Fibrillation requiring admission to hospital for the treatment of intra-venous antiarrhythmic therapy.

**Endovascular Repair of Aortic Aneurysm**

The repair through endovascular methods of an aortic aneurysm with the replacement of a portion of the diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

**Femoral Artery Aneurysm Repair**

Surgical repair of an aneurysm of the femoral artery by surgery or by endovascular techniques.

**Heart Attack**

Death of heart muscle, due to inadequate blood supply, that has resulted in the following evidence of acute myocardial infarction:

- New characteristic electrocardiographic changes, and
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher;
  - Troponin T > 1.0 ng/ml
  - AccuTnl > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- Other acute coronary syndromes including but not limited to angina.

**Heart Valve Replacement or Repair**

The undergoing of surgery on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

**Heart Attack resulting in a Reduced Ejection Fraction**

A heart attack causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 39% or less. The measurement must be performed at least one month after an acute heart attack. The heart attack must have been diagnosed according to the criteria stated under the Heart Attack definition in provision 1 b) i above for a claim to be considered.

**Iliac Artery Aneurysm Repair**

Surgical repair of an aneurysm of the iliac artery by surgery or by endovascular techniques.

**Infective Endocarditis**

Endocarditis is the infection on the valves of the heart with vegetations (clumps of small clot and bacteria) visible on the echocardiogram.

There must be echocardiographic evidence of vegetation on the valves of the heart, and blood cultures must show bacterial growth in at least two samples taken at the same time. Endocarditis as a result of drug misuse is not covered.

**Keyhole Coronary Artery Bypass Surgery**

The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts via a thoroscope or mini thoracotomy.

**Pericardectomy**

The surgical excision of part of the pericardium surrounding the heart via thoracotomy or sternotomy to relieve a constriction of the heart. Biopsy and aspiration of pericardial effusion is excluded.

**Permanent Defibrillator Insertion**

The *permanent* insertion of an automatic implantable defibrillator after the occurrence of ventricular tachycardia or ventricular fibrillation.

**Permanent Pacemaker Insertion**

The *permanent* insertion of an artificial pacemaker to correct an abnormal rhythm of the heart. The abnormal rhythm of the heart must have been documented on electrocardiograph (ECG) and be available to us.

**Severe Peripheral Vascular Disease**

There must be severe restriction of blood flow through the arteries below the knee as measured by doppler readings of less than 30 per cent of normal and a claudication distance of 20 metres. Surgery must have failed to reverse this or be contraindicated for reasons as agreed by *Prudential's* Chief Medical Officer.

**Severe Vascular Disease affecting Multiple Systems**

Severe vascular disease affecting the heart, kidney and/or brain. There must be at least 2 of the following:

- Stroke\* ;
- left ventricular hypertrophy measured by a ratio of the thickness of the septal wall to the posterior left ventricular wall of 1:1.3;
- renal dysfunction measured by blood urea greater than 15mmol/l and serum creatinine greater than 200mmol/l;
- grade 4 retinopathy;

combined with an elevated blood pressure with a diastolic reading i.e. pressure in the left ventricle during the resting phase greater than 110mmHg on *optimal therapy*.

\*For the purposes of this *plan* a stroke is an acute event, requiring admission to hospital, as diagnosed by a Consultant Neurologist or stroke physician. There must be residual deficit with a Modified Rankin Scale of 2 or above.

#### **Surgery for Cardiac Arrhythmia**

The surgical or endovascular division or ablation of abnormal conduction pathways to correct an abnormal rhythm of the heart. The abnormal rhythm of the heart must have been documented on electrocardiograph (ECG) and be available to *us*.

#### **Surgery to correct Carotid Artery Stenosis**

Therapeutic correction by open surgical techniques with endarterectomy of symptomatic stenosis of the carotid artery.

#### **Surgical repair of an Atrial or Ventricular Septal Defect**

The surgical closure of a defect in the interatrial or interventricular septum. This can be performed through a thoracotomy, a sternotomy or by using endovascular techniques.

#### **Surgical repair of a Structural Lesion of the Heart**

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to repair a structural lesion of the heart.

## 2 SEVERITY LEVELS

### How is severity measured?

#### **Reduction in ejection fraction:**

The ejection fraction is a measure of the efficiency of the pumping action of the heart; in a healthy heart this is typically greater than 50%. Damage to the muscle of the heart (myocardium) such as that sustained during myocardial infarction or cardiomyopathy, impairs the heart's ability to eject blood and therefore reduces ejection fraction. Where a severity is measured by the *permanent* reduction in ejection fraction it is measured by the percentage of the contents of the left ventricle that is expelled in each contraction of the ventricle. This can be measured by echocardiography or through radioisotope measurements. It must be measured in a cardiac laboratory, which has regular quality control audits available to *us*, and be supervised by a Consultant Cardiologist.

The disease or disorder causing the reduction in ejection fraction must be established as being *permanent* and *irreversible* and the measurement must be taken whilst the patient is on optimal treatment.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

#### Severity Level A:

- Cardiomyopathy resulting in a *permanent* ejection fraction of 29% or less whilst on *optimal therapy*\*.
- Heart attack resulting in a *permanent* ejection fraction of 29% or less whilst on *optimal therapy*\*.
- Any other cardiac condition resulting in a *permanent* ejection fraction of 29% or less whilst on *optimal therapy*\*.
- At least 4 signs of congestive heart failure on *optimal therapy* for at least 6 months.
- Severe vascular disease affecting multiple systems with a diastolic blood pressure greater than 110mmHg on *optimal therapy*.
- Severe peripheral vascular disease.

#### Severity Level B:

- Cardiomyopathy resulting in a *permanent* ejection fraction of between 30% and 39% whilst on *optimal therapy*\*.
- Heart attack resulting in a *permanent* ejection fraction of between 30% and 39% whilst on *optimal therapy*\*.
- Any other cardiac condition resulting in a *permanent* ejection fraction of between 30% and 39% whilst on *optimal therapy*\*.
- Aorta Graft Surgery.
- By-pass Graft Surgery to three or more Coronary Arteries.

\*See 'How is severity measured?' (above) for details as to how a reduction in ejection fraction is measured.

#### Severity Level C:

- Coronary Artery By-pass Grafts
- Heart Attack.

#### Severity Level D:

- Surgical Repair of a Structural Lesion of the Heart
- Heart Valve Replacement or Repair
- Endovascular Repair of an Aortic Aneurysm.

#### Severity Level E:

- Iliac Artery Aneurysm Repair
- Femoral Artery Aneurysm Repair
- Balloon Valvuloplasty
- Pericardectomy
- Surgery to correct Carotid Artery Stenosis.

**Severity Level F:**

- Angioplasty (Coronary) or PTCA (Percutaneous Transluminal Coronary Angioplasty) with or without stent
- Angioplasty to correct Carotid Artery Stenosis
- Keyhole Coronary Artery Bypass Surgery
- *Permanent* Pacemaker Insertion
- *Permanent* Defibrillator Insertion
- Surgery for Cardiac Arrhythmia
- Infective Endocarditis
- Surgical Repair of an Atrial or Ventricular Septal Defect
- Cardioversion for Cardiac Arrhythmia
- Emergency Intravenous Anti-arrhythmic therapy for Ventricular Tachycardia or Fibrillation.

**3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM**

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- History of signs and symptoms compatible with the condition claimed.
- Full cardiologist's, cardiothoracic, neurosurgeon or vascular surgeon's assessment and operation notes.
- Relevant electrocardiographs, angiograms, aortograms, thallium scans, echocardiograms, X-rays, CT scans or any other relevant test results and reports.
- Cardiac enzyme results for heart attacks. Raised serum CKMB fraction or positive Troponin-T or I, if performed. Raised creatinine kinase and LDH alone are not considered.

**4 SPECIFIC EXCLUSIONS**

- Any Acute coronary syndromes which do not completely satisfy any of the definitions listed in the Definitions section of this illness category including, but not limited to, angina.
- Alcoholic Cardiomyopathy.
- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.
- Any second claim at any time under any of the Severity Level F procedures listed in provision 1 b) 2 above.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.

- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

**1.c Stroke and Nervous System category—specified conditions of defined severity****1 DEFINITIONS****Alzheimer's disease**

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember;
- reason; and
- perceive, understand, express and give effect to ideas.

For the above definition, the following are not covered:

- Other types of dementia.

**Bacterial Meningitis**

Confirmation by a Consultant Physician of a definite diagnosis of Bacterial Meningitis supported by cerebrospinal fluid changes consistent with bacterial meningitis. All other forms of meningitis, including viral, are not covered.

**Benign Brain Tumour**

A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, resulting in either surgical removal or *Permanent Neurological Deficit With Persisting Clinical Symptoms*. For the above definition, the following are not covered:

- Tumours in the pituitary gland
- Angiomas.

**Bilateral Hemianopia**

*Permanent* and *irreversible* loss of vision in one half of the visual field of both eyes.

**Coma - resulting in permanent symptoms**

A state of unconsciousness which:

- Requires the use of life support systems; and
- results in *permanent* neurological deficit with persisting clinical symptoms.

The following is not covered:

- Coma secondary to *alcohol or drug abuse*.

**Craniotomy**

Any surgical treatment of brain tissue via craniotomy by a Consultant Neurosurgeon for any of the following:

- Intracranial infections
- Subdural, Intracerebral and Epidural Haematomas or Subarachnoid bleeds
- Traumatic Brain Injury

For the above definition, the following are not covered:

- Burr Holes procedures
- Insertion of deep brain stimulators

**Craniotomy to treat a Cerebral Arteriovenous Malformation**

Surgical treatment via craniotomy by a Consultant Neurosurgeon of a cerebral AV fistula or aneurysm.

**Creutzfeldt-Jakob Disease**

A definite diagnosis of Creutzfeldt-Jakob disease by a Consultant Neurologist, Psychiatrist or Geriatrician. This must have been reported to the National CJD Monitoring Unit as a confirmed case. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember;
- reason; and
- perceive, understand, express and give effect to ideas.

**Dementia**

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember;
- reason; and
- perceive, understand, express and give effect to ideas.

**Drainage of Brain Abscess by Craniotomy**

The surgical drainage of an intracerebral abscess within the brain tissue through a craniotomy by a Consultant Neurosurgeon. There must be evidence of an intracerebral abscess on CT or MRI imaging.

**Encephalitis**

A definite diagnosis of Encephalitis by a Consultant Neurologist, resulting in *Permanent Neurological Deficit With Persisting Clinical Symptoms*.

**Endovascular Treatment of a Cerebral Arteriovenous Malformation**

Endovascular treatment by a Consultant Neurosurgeon or Radiologist using coils to cause thrombosis of a cerebral AV fistula or aneurysm.

**Functional Surgery for Movement Disorders**

Undergoing of surgery, in the form of deep brain stimulation, to treat tremor, parkinsonism, dyskinesia, or dystonia.

**Guillain-Barré Syndrome**

A definite diagnosis of Guillain-Barré Syndrome by a Neurologist, confirmed by electromyography and lumbar puncture. There must be evidence of continual and *permanent* weakness or numbness being present for a minimum period of 2 years, which is supported by appropriate neurological evidence. The residual deficit must measure at least 3 on the Modified Rankin Scale.

**Loss of Manual Dexterity to age 70**

Total and *irreversible* loss of the ability to use the hands and fingers with precision to perform daily activities of work such as picking up or manipulating small objects, operating a range of equipment manually or communicating through writing or typing. The disability must be *permanent* and supported by appropriate neurological evidence.

**Loss of Muscle Power resulting in the inability to grip to age 70**

Total and *irreversible* loss of all muscle power in both hands resulting in the inability to grip any tool, utensil or assistive device. The disability must be *permanent* and supported by appropriate neurological evidence.

**Loss of Speech**

Total *permanent* and *irreversible* loss of the ability to speak as a result of physical injury or disease.

**Motor Neurone Disease**

A definite diagnosis of motor neurone disease by a Consultant Neurologist. There must be *permanent* clinical impairment of motor function.

**Multiple Sclerosis**

A definite diagnosis of Multiple Sclerosis by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least six months.

**Muscular Dystrophy**

The definite diagnosis of Muscular Dystrophy by a Consultant Neurologist which must be supported by typical changes on muscle biopsy.

**Neurological Diseases**

For the purpose of this *plan* this includes any *permanent irreversible* disease affecting the basal ganglia, cerebellum, neurones, horn cells or myelin sheaths that produce identifiable *permanent* neurological deficit. If the disease, disability or symptom is not defined as a named condition in this provision 1 c) i, *benefits* will be

paid only when there is an inability to perform the *functional activity tests* see provision D5.4. *Alcohol or drug abuse* is excluded.

#### Paralysis of limbs

Total and *irreversible* loss of muscle function to the whole of any two limbs.

#### Parkinson's Disease

A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be *permanent* clinical impairment of motor function with associated tremor, rigidity of movement and postural instability. For the above definition, the following is not covered:

- Parkinson's disease secondary to drug abuse.

#### Persistent Vegetative State to age 70

A severe neurological condition of decreased consciousness where there must be all of the following:

- The loss of an awareness of surroundings;
- the lack of speech;
- the lack of response to commands; and
- the lack of any purposeful movements.

This condition must be *permanent* and supported by appropriate neurological evidence.

#### Progressive Supra-nuclear Palsy

Confirmation by a Consultant Neurologist of a definite diagnosis of Progressive Supra-nuclear Palsy. There must be *permanent* clinical impairment of motor function.

#### Shunt Insertion for Hydrocephalus

Surgical insertion of a *permanent* drainage shunt for the treatment of hydrocephalus. There must be enlargement of the ventricles which has been confirmed by a radiologist.

#### Spinal Tumour

A primary tumour of the spinal cord resulting in *Permanent Neurological Deficit With Persisting Clinical Symptoms*. The diagnosis must be supported by CT, MRI or histopathological evidence. For the above definition, only the following tumours are covered:

- Meningioma
- Neurofibroma
- Astrocytoma
- Ependymoma
- Chordoma

#### Stereotactic Brain Surgery

Undergoing stereotactic surgery to the brain performed by a Consultant Neurosurgeon for neurological disease. Biopsy of brain tissue is specifically excluded.

#### Stroke

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in *permanent neurological deficit with persisting clinical symptoms*. For the above definition, the following are not covered:

- Transient ischaemic attack
- Traumatic injury to brain tissue or blood vessels.

#### Surgery for Drug Resistant Epilepsy

Undergoing of surgery to brain tissue in order to control epilepsy that cannot be controlled by oral medication.

#### Surgical Repair of Depressed Skull Fracture

Undergoing surgery to correct a depression in the skull as a result of an accidental traumatic fracture or break in the cranial bone.

#### Traumatic head injury

Death of brain tissue due to traumatic injury resulting in *permanent neurological deficit with persisting clinical symptoms*.

## 2 SEVERITY LEVELS

### How is severity measured?

**Modified Rankin Scale:** Severity of a stroke is measured by the Modified Rankin Scale (van Swieten et al., 1988). This is an internationally accepted measure of disability for neurological conditions, especially stroke. It is scored from 0 to 5, with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

**Functional Activity Tests (FATs):** For neurological diseases (including those not specifically stated under this *benefit*) we will pay a *benefit* if you become *permanently* unable to perform certain *functional activity tests* due to the disease.

If you are aged 65 or over at the time of a claim we will assess the claim on the failure to perform a number of *activities of daily living* (ADLs). The severity of the *benefit* increases should you become increasingly unable to perform more ADLs.

If, however, you are aged between 16 and 65 at the time of the claim, we will also consider whether the Incapacity resulting from your *life-changing event* causes an inability to perform any *activities of daily work*. Assessment of your claim will only be made on one group of *functional activity tests*, either *activities of daily work* (ADW) or *activities of daily living* (ADL). Please note that there will be no accumulation of an inability to perform ADLs and ADWs when counting the number of failures of tasks but we will use the set of *functional activity tests* most favourable to you. See provision D5.4 for full details of these *functional activity tests*.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

#### Severity Level A:

- A Stroke with a residual deficit measuring 4 or above on the Modified Rankin Scale.
- Any Neurological Disease causing the *permanent* and *irreversible* inability to perform four out of six *functional activity tests*. See provision D5.4.
- Loss of Speech.
- Paralysis of limbs.
- Loss of Manual Dexterity.
- Loss of muscle power resulting in the inability to grip.
- Persistent Vegetative State.

#### Severity Level B:

- A Stroke with a residual deficit measuring at least 3 on the Modified Rankin Scale.
- Any Neurological Disease causing the *permanent* and *irreversible* inability to perform three out of six *functional activity tests*. See provision D5.4.
- Bilateral Hemianopia.
- Guillain-Barré Syndrome with a residual deficit measuring at least 3 on the Modified Rankin Scale.

#### Severity Level C:

- A Stroke with a residual deficit measuring at least 2 on the Modified Rankin Scale.
- Any Neurological Disease causing the *permanent* and *irreversible* inability to perform two out of six *functional activity tests*. See provision D5.4.
- Surgery for Drug Resistant Epilepsy.

#### Severity Level D:

- A Stroke\*
- Craniotomy to treat a Cerebral Arteriovenous Malformation
- A Benign Brain Tumour\*
- Progressive Supra-nuclear Palsy\*
- Functional Surgery for Movement Disorders
- Shunt Insertion for Hydrocephalus (restricted to one payment only)
- Coma\*
- Multiple Sclerosis\*
- Parkinson's Disease\*
- Alzheimer's Disease\*
- Dementia\*
- Creutzfeldt-Jakob Disease\*
- Motor Neurone Disease\*
- Muscular Dystrophy\*

- Traumatic head injury\*
- Encephalitis \*
- Spinal Tumour
- Craniotomy
- Drainage of Brain Abscess by Craniotomy.

\*these conditions can be continually re-assessed as they progress in severity by use of the Modified Rankin Scale or *functional activity tests* (FATs) as described in 'How is severity measured' above. Please also refer to provision B2.7.

#### Severity Level E:

- Surgical Repair of Depressed Skull Fracture
- Endovascular treatment of a Cerebral Arteriovenous Malformation

#### Severity Level F:

- Stereotactic Brain Surgery
- Bacterial Meningitis

### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms must be present.
- Relevant investigations must be done and the results available, including CT scan or MRI imaging, or any other relevant investigation results.
- Diagnosis made by an appropriate medical specialist.
- Loss of neurological function compatible with area of damage of the brain involved.

### 4 SPECIFIC EXCLUSIONS

- Any condition stated in 1c) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner.
- Parkinson's disease secondary to alcohol or drug abuse.
- Pituitary tumours – specified treatments are covered within the Endocrine *benefit*.
- Transient Ischaemic Attacks.
- Benign intracranial hypertension.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.

- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 1.d Gastrointestinal category – specified conditions of defined severity

### 1 DEFINITIONS

#### Chronic Inflammatory Hepatitis

An inflammation of the liver which has been present for at least one year. There must be all of the following:

- Abnormal liver function tests including liver enzymes called transaminases to at least three times normal laboratory range throughout this period;
- moderate plate necrosis or severe focal cell necrosis on liver biopsy; and
- periportal or septal fibrosis on liver biopsy. Causes of this condition can include chronic Hepatitis B or C or Autoimmune Disease.

#### Chronic Pancreatitis

Chronic Inflammation of the pancreas with calcification throughout the body and tail of the gland. There must also be all of the following:

- Proof of calcification on CT scan;
- evidence of failure of secretion of pancreatic enzymes; and
- evidence of chronic inflammation on Endoscopic Retrograde Cholangiopancreatography (ERCP) or Magnetic Resonance Cholepancreatography (MRCP).

#### Cirrhosis of the Liver

A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy.

#### Fulminant Hepatic Necrosis

Massive necrosis (death of liver tissue) with clotting deficiencies and metabolic abnormalities which cause coma occurring in an individual without any previous liver disease. There must be jaundice, encephalopathy and admission to a specialist liver unit.

#### Loss of the use of more than one third of the tongue

Loss of the use of more than one third of the

tongue through loss of motor function, traumatic amputation or through surgery.

#### Moderately Severe Inflammatory Crohn's Disease

A definite diagnosis of Crohn's Disease by a Consultant Gastroenterologist. To meet the definition of moderate, at least 2 sites of deep tissue intestinal tract must be affected by continued or relapsing inflammation, with 2 or more flare-ups each year. Each flare up must require courses or increased dosages of either oral or intravenous steroids or immunosuppressants.

#### Partial Hepatectomy

The surgical excision of at least 25% of the liver mass by laparotomy. Liver biopsy and donation are specifically excluded.

#### Permanent Faecal Incontinence to age 70

There must be *permanent* incontinence of faeces with constant soiling, despite *optimal therapy* for a period of one year. This must require daily pads as prescribed by a consultant physician or surgeon.

#### Permanent Rectal Fistula

A *permanent* abnormal tract or connection between the rectum and the skin, bladder or vagina due to a disease of the rectum. There must be radiological evidence of the abnormal tract or connection. Fistula in ano is specifically excluded.

#### Portal Vein Thrombosis

The thrombosis of the portal vein causing ascites and enlargement of the spleen. There must be radiological evidence of the blockage to the portal vein as well as proof of oesophageal varices as a complication.

#### Sclerosing Cholangitis

An inflammation of the bile ducts proven on cholangiography, with abnormal liver function tests. There must be diagnostic appearances with irregular stricturing and dilatation on Endoscopic Retrograde Cholangiopancreatography (ERCP) or Magnetic Resonance Cholepancreatography (MRCP).

#### Severe Cirrhosis of the Liver

A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy. To be considered as severe the following must be present for at least one year and there must be all of the following throughout this period:

- Persistent jaundice marked by elevated bilirubin levels above 50 micromols/litres;
- abnormal protein production marked by decreased albumin levels below 27 G/L; and
- abnormal clotting of the blood marked by a Prothrombin time above two times the normal limit or an International Normalisation Ratio (INR) test above 2.0.

#### Severe Inflammatory Crohn's Disease

A definite diagnosis of Crohn's Disease by a Consultant Gastroenterologist. To be considered as severe, symptoms must not have responded to optimal therapy while under the continued supervision of a Gastroenterologist. There must also be evidence of continued inflammation with all of the following having occurred:

- Stricture formation causing intestinal obstruction requiring admission to hospital, and
- Fistula formation between loops of bowel or bowel to another organ, and
- At least one resection of a segment of small bowel

#### Surgical Repair of a Tracheo-Oesophageal Fistula

The surgical repair of an abnormal tract between the trachea and oesophagus as demonstrated by radiological methods.

#### Total Colectomy

Removal of the whole of the colon creating an opening on the abdomen joining the small intestine to the abdomen wall called an Ileostomy. This procedure is covered if it is established that the ileostomy is *permanent* in the opinion of both a Consultant Gastroenterologist and *our* Chief Medical Officer.

## 2 SEVERITY LEVELS

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

#### Severity Level A:

- Fulminant Hepatic Necrosis
- *Permanent* Faecal Incontinence
- Severe Cirrhosis of the Liver.

#### Severity Level C:

- Sclerosing Cholangitis
- Severe Inflammatory Crohn's Disease

#### Severity Level D:

- Chronic Pancreatitis
- Total Colectomy.

#### Severity Level E:

- Cirrhosis of the Liver
- Chronic Inflammatory Hepatitis
- Partial Hepatectomy
- Portal Vein Thrombosis
- Loss of use of more than one third of the Tongue.

#### Severity Level F:

- Surgical Repair of a Tracheal-Oesophageal Fistula
- *Permanent* Rectal Fistula.
- Moderately Severe Inflammatory Crohn's Disease

## 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed.
- Diagnosis and treatment by an appropriate medical specialist.
- Relevant investigations, results, copies of hospital and histology reports signed by suitably qualified Consultant Histopathologist.

## 4 SPECIFIC EXCLUSIONS

- Any condition stated in 1d) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner.
- *Alcohol or drug abuse*.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 1.e Connective Tissue Diseases category – specified conditions of defined severity

### 1 DEFINITIONS

For the purposes of this *plan* other diseases which are not specifically named such as sero-negative arthritis, psoriatic arthritis or osteoarthritis are not covered by this *plan*, but complications of these diseases may be paid out should criteria be met under any of the other categories of illnesses.

#### Giant Cell Arteritis

The definite diagnosis of Giant Cell Arteritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

#### Pemphigus Vulgaris

A chronic, relapsing autoimmune skin disease that causes blisters and erosions of the skin and mucous membranes. For the purpose of this *plan* only Pemphigus Vulgaris is covered, with the diagnosis supported by a biopsy and presence of PV auto-antibodies in the blood.

#### Polyarteritis Nodosa

The definite diagnosis of Polyarteritis Nodosa by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

#### Polymyositis

Polymyositis is an inflammatory disease affecting the muscles of the limbs especially the larger muscles. For the purpose of this illness category there must be all of the following:.

- Elevated serum muscle enzymes (CK, aldolase);
- Electromyographic findings typical of dermatomyositis (DM) or polymyositis (PM);
- muscle biopsy findings typical of PM or DM (as defined immediately above); and
- compatible weakness – symmetrical proximal muscle weakness for which there is no other explanation.

#### Rheumatoid Arthritis

The definite diagnosis of Rheumatoid Arthritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

#### Systemic Lupus Erythematosus (SLE)

The definite diagnosis of Systemic Lupus Erythematosus (SLE) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

#### Systemic Sclerosis (Scleroderma)

The definite diagnosis of Systemic Sclerosis (Scleroderma) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

#### Wegener's Granulomatosis

The definite diagnosis of Wegener's Granulomatosis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

## 2 SEVERITY LEVELS

### How is severity measured?

**Connective Tissue Diseases:** Connective tissue diseases are a group of autoimmune diseases, which means that the body attacks itself, especially joints, blood vessels, kidneys, lungs and other organs. For the purposes of this *plan* the severity of Connective Tissue Diseases will be determined by the *permanent* inability to perform a number of *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*. If you are aged 65 or over at the time of a claim, we will assess the claim on the failure to perform a number of *activities of daily living* (ADLs). The severity of the *benefit* increases should you become increasingly unable to perform more ADLs.

If, however, you are aged between 16 and 65 at the time of the claim, we will also consider whether the incapacity resulting from your *life-changing event* causes an inability to perform any *activities of daily work* (ADW). Assessment of your claim will only be made on one group of *functional activity tests*, either *activities of daily work* (ADW) or *activities of daily living* (ADL). Please note that there will be no accumulation of an inability to perform ADLs and ADWs when counting the number of failures of tasks but we will use the set of *functional activity tests* most favourable to you. See provision D5.4 for full details of these *functional activity tests*.

The amount of the claim depends on the severity of the illness you suffer. The following levels apply:

#### Severity Level A:

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosus, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the *permanent* inability to perform at least four out of six *functional activity tests*. See provision D5.4.

**Severity Level B:**

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosus, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the *permanent* inability to perform at least three out of six *functional activity tests*. See provision D5.4.

**Severity Level C:**

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosus, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the *permanent* inability to perform at least two out of six *functional activity tests*. See provision D5.4.

**Severity Level D:**

Giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosus, systemic sclerosis (scleroderma) or Wegener's granulomatosis causing the *permanent* inability to perform at least one out of six *functional activity tests*. See provision D5.4.

**Severity Level F:**

- A definite diagnosis of giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosus, systemic sclerosis (scleroderma) or Wegener's granulomatosis.
- Pemphigus Vulgaris

**3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM**

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant blood tests and tissue biopsies which satisfy the relevant defined diagnostic criteria.
- Histological proof of the presence of the disease.

**4 SPECIFIC EXCLUSIONS**

- Fibromyalgia, or any synonym including, but not limited to, fibromyositis, fibrositis, muscular rheumatism, myofascial pain syndrome.
- Osteoarthritis, wear and tear or any other subjective, non-diagnosed condition.
- Chronic fatigue syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free disease.

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 1.f Urogenital Tract and Kidney category – specified conditions of defined severity

### 1 DEFINITIONS

#### Acute Renal Dialysis

Undergoing more than two treatments of haemodialysis over a three week period or a cumulative total of more than 24 hours haemofiltration due to a rapid decline of renal function leading to renal failure.

#### Bilateral Orchidectomy

The therapeutic surgical removal of all of both testicles due to trauma or for the treatment of a disease of the testicles or of the blood vessels supplying the testicles.

#### Bladder Fistula

The abnormal connection or tract between the bladder and the skin, vagina or rectum due to disease of the bladder. This must be proven by radiological evidence.

#### Chronic Renal Impairment

The impairment in kidney function such that the estimated glomerular filtration rate is below 25 mls/litre/min/1.73 m<sup>2</sup> surface area persistently for a period of six months or more.

#### Cystectomy

The surgical removal of the complete organ of the bladder with the construction of a urostomy or nephrostomies to allow urine to be collected external to the body. If the surgical removal is due to cancer of the bladder, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below.

#### Kidney Failure

Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is necessary.

#### Nephrectomy

Undergoing the surgical removal of a complete kidney as a result of documented renal disease or trauma. If the surgical removal is due to cancer of the kidney, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below.

#### Partial Cystectomy

Undergoing the surgical removal of at least 50% of the bladder, measured by surface area, as a result of documented disease or trauma. If the surgical removal is due to cancer of the bladder, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below.

#### Partial Nephrectomy

Undergoing the surgical removal of at least 30% of the mass of one kidney as a result of documented disease or trauma. If the surgical removal is due to cancer of the kidney, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below. Biopsy is excluded.

#### Severe Chronic Renal Impairment

The impairment in renal function such that the estimated glomerular filtration rate is below 15 mls/ litre/min/1.73 m<sup>2</sup> surface area persistently for a period of six months or more.

#### Surgical Repair of a Kidney

Surgical repair of acute damage to the kidney as a result of trauma. Keyhole surgery, including laparoscopic surgery, is specifically excluded.

## 2 SEVERITY LEVELS

### How Is Severity Measured?

**Renal function:** Severity is measured by the estimated glomerular filtration rate. This is a measure of the efficiency of the kidneys as a filter. The amount of the claim depends on the severity of the illness you suffer. The following levels apply:

#### Severity Level A:

- Kidney Failure

#### Severity Level B:

- Severe Chronic Renal Impairment

#### Severity Level C:

- Chronic Renal Impairment
- Cystectomy.

#### Severity Level D:

- Acute Renal Dialysis
- Nephrectomy
- Partial Cystectomy.

#### Severity Level E:

- Partial Nephrectomy
- Bilateral Orchidectomy
- Surgical repair of a Kidney.

#### Severity Level F:

- Bladder Fistula

### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5

Any or all of the following may apply to any claim under this category

- Diagnosis and treatment by an appropriate medical specialist.
- Copies of all available specialist reports.
- Details of current and historic renal function tests.
- Histology of biopsies and any other relevant investigations must be available.

### 4 SPECIFIC EXCLUSIONS

- Kidney transplant. This is covered in the Major Organ Transplant category.
- Kidney donation.
- Elective gender reassignment.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 1.g Respiratory Disease to Age 70 category – specified conditions of defined severity

### 1 DEFINITIONS

#### Chronic Obstructive Pulmonary Disease

A disease of the airways of the lung causing obstruction to the exhalation of air. There must be *permanent* and *irreversible* reduction of the maximum volume of air expelled in one second (FEV1) of less than 50% of predicted.

There must be *permanent* and *irreversible* obstruction to airflow demonstrated by a FEV1/ FVC ratio of less than 50% and there must be less than 5% variation in three repeated measurements, (which must be performed under the direction of a specialist respiratory physician) whilst on *optimal therapy*. They must be measured in a respiratory laboratory, which has regular quality control audits available to us.

These measurements must be repeated after an interval of at least three months and must also satisfy the criteria mentioned above for a claim to be considered.

Only the following severities are covered:

- Stage III – where FEV1 is between 31% and 49% of predicted
- Stage IV – where FEV1 is 30% or less of predicted.

When both Chronic Obstructive Pulmonary Disease and Fibrotic Lung Disease co-exist, only one payment will be made for the condition which is at the highest severity level.

#### Cor Pulmonale

*Irreversible* right ventricular failure due to a lung disease producing raised pulmonary artery pressure (Pulmonary Hypertension). There must be evidence of raised pulmonary artery pressure of at least 30mmHG (mm of mercury) and there must also be right ventricular dilatation and hypertrophy on echocardiogram with characteristic ECG changes.

#### Fibrotic Lung Disease

For the purpose of this *plan* fibrotic lung disease is defined as one of the following only:

- Sarcoidosis
- Fibrosing Alveolitis
- Aspergilosis

These fibrotic lung diseases produce thickening and fibrosis of the finest membranes in the alveoli that allow transfer of oxygen into the blood stream.

There must be radiological evidence of fibrosis and there must be a *permanent and irreversible* restriction of Vital Capacity (VC), the maximum total volume of air that can be expelled from the lung after maximum inhalation, to below 75% of predicted. There must also be a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 55% of predicted or less.

These tests must be performed under the direction of a specialist respiratory physician whilst on *optimal therapy*. They must be measured in a respiratory laboratory, which has regular quality control audits available to us, and be supervised by the treating specialist. When both chronic obstructive pulmonary disease and fibrotic lung disease co-exist, only one payment will be made (for the condition which is at the highest severity level).

#### Home Oxygen Therapy

Severe obstructive lung disease with a FEV1 of less than 1 litre present for at least 1 year as well as a concentration of oxygen in the arteries of less than 7.3 kPa. Supplemental oxygen therapy must be used at home for at least 13 hours each day.

#### Mechanical Ventilatory Support for Near Drowning

Mechanical ventilatory support for at least 24 hours following full resuscitation as a consequence of near drowning.

#### Pleurectomy

The therapeutic surgical excision of the pleura (the membrane covering the lungs) for documented disease.

#### Primary Pulmonary Hypertension

The presence of *irreversible* raised pressure in the Pulmonary arteries. The measurement reported must be the average level measured by cardiac catheterisation and be at least 30mmHG (mm of mercury) at rest. There must also be right ventricular dilatation and hypertrophy on echocardiogram with characteristic ECG changes.

#### Pulmonary Embolus

The blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs) or an angiography.

#### Removal of One Lobe of the Lungs

The therapeutic surgical removal of one lobe of the lungs for documented disease or trauma.

#### Removal of Two or more Lobes of the Lungs

The therapeutic surgical removal of two or more lobes of the lungs for documented disease or trauma.

#### Surgical Drainage of a Lung Abscess

The surgical drainage of an abscess in the parenchyma of the lung using a thoracotomy.

#### Surgical Drainage of Empyema

The collection of pus in the pleural space. This is the space between the lung and the ribcage. The empyema must have been drained using a thoracotomy operation to qualify for this *benefit*.

## 2 SEVERITY LEVELS

### How Is Severity Measured?

#### Chronic Obstructive Pulmonary Disease:

Severity is assessed by the measurement of:

1. Vital Capacity (VC). This is the maximum total volume of air that can be expelled from the lung after maximum inhalation.
2. The Forced Expiratory Volume 1 (FEV1). The maximum volume of air expelled in one second.
3. The ratio of the two measurements. Fibrotic Lung Disease: The severity is measured by the Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco), that is the measurement that reflects the transfer of gases across the membranes of the lung into the blood stream from the air. This can only be performed in a lung function laboratory. It is called the transfer factor. The amount of the claim depends on the severity of the illness you suffer.

The following levels apply:

#### Severity Level A:

- Fibrotic Lung disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 34% of predicted or less
- Cor Pulmonale
- Primary Pulmonary Hypertension.

#### Severity Level C:

- Fibrotic Lung Disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 35% and 39% of predicted
- Home Oxygen Therapy
- Stage IV Chronic Obstructive Pulmonary Disease
- Removal of two or more lobes of the lungs.

**Severity Level D:**

- Fibrotic Lung Disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 40% and 49% of predicted
- Stage III Chronic Obstructive Pulmonary Disease
- Removal of one lobe of the lungs.

**Severity Level E:**

- Surgical Drainage of a Lung Abscess
- Surgical Drainage of Empyema
- Pleurectomy
- Pulmonary Embolus.

**Severity Level F:**

- Mechanical Ventilatory Support for Near Drowning.
- Fibrotic Lung Disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 50% and 55% of predicted.

**3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM**

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed.
- Must be diagnosed and treated by an *appropriate medical specialist*.
- Relevant pulmonary and cardiac investigations must be done and be available.
- Histology report must be available if needed.

**4 SPECIFIC EXCLUSIONS**

- Any condition stated in 1g) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner.
- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs;
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

**1.h Accidental HIV category – meeting specified criteria****1 DEFINITIONS****HIV infection.**

Infection by Human Immunodeficiency Virus resulting from:

- A blood transfusion given as part of medical treatment;
- a physical or sexual assault; or
- an incident occurring during the course of performing normal duties of *employment* from the eligible *occupations* listed below;

after the start of the *plan* and satisfying all of the following:

- The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.
- Where HIV infection is caught through a physical or sexual assault or as a result of an incident occurring during the course of performing normal duties of *employment*, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident.
- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.
- The incident causing infection must have occurred in the *United Kingdom*, the Channel Islands, the Isle of Man or the Republic of Ireland.

For the above definition, the following is not covered:

- HIV infection resulting from any other means, including sexual activity or drug abuse.

The eligible *occupations* covered by this *benefit* are as follows:

- Ambulance Workers
- Chiropodists
- Dental Nurses
- Dental Surgeons
- District Nurses
- Fire Brigade Fire-fighters
- General Practitioners
- Hospital Caterers
- Hospital Cleaners
- Hospital Doctors, Surgeons and Consultants
- Hospital Laboratory Technicians
- Hospital Laundry Workers

- Hospital Nurses
- Hospital Porters
- Midwives
- Nurses *employed* by General Practitioners
- Occupational Therapists
- Paramedics
- Physiotherapists
- Podiatrists
- Policemen and Policewomen
- Prison Officers
- Radiologists
- Refuse Collectors
- Social Workers.

## 2 SEVERITY LEVELS

### Severity Level A:

HIV infection resulting from:

- A blood transfusion given as part of medical treatment,
- or a physical or sexual assault,
- or an incident occurring during the course of performing normal duties of *employment* from the list of eligible *occupations*.

## 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

We will require evidence of a negative HIV test within 5 days of the incident and the subsequent positive HIV (Human Immunodeficiency Virus) antibody test with a confirmatory Western Blot test within 12 months of the incident.

## 4 SPECIFIC EXCLUSIONS

- Any method of infection of HIV or AIDS that is not stated above.
- Transmission through *occupational* duties for any *occupation* other than those specified above in provision 1 h) i.
- No cover under this *benefit* is effective unless there is shown to be a negative HIV test within five days of the incident causing the claim.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 1.i Musculoskeletal Trauma category – specified conditions of defined severity

### 1 DEFINITIONS

#### Amputation of Two or More Fingers or Thumbs

*Permanent* physical severance of two or more fingers or thumbs at the metacarpal bone.

#### Le Fort III Reconstruction

This is a form of surgical repair of the maxillofacial bones for severe facial trauma.

#### Less Extensive Third Degree Burns – covering 15% of the body's surface area

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 15% of the body's surface area.

#### Less Extensive Third Degree Burns – covering 10% of the body's surface area

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 10% of the body's surface area.

#### Less Extensive Third Degree Burns – covering 5% of the body's surface area

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% of the body's surface area.

#### Loss of a single hand or foot

The *permanent* physical severance of either hand or either foot at or above the wrist or ankle joints.

#### Loss of a single limb

The *permanent* physical severance of a single limb from above the knee or elbow joint or the total loss of motor power to the entire limb.

#### Loss of hands or feet

*Permanent* physical severance of any combination of two or more hands or feet at or above the wrist or ankle joints.

#### Loss of the use of a Whole Hand

Total and *irreversible* loss of muscle function or sensation to the whole of a hand due to trauma. The disability must be *permanent* and supported by appropriate neurological evidence.

#### Surgical Re-attachment of an Amputated Limb

Surgery to re-attach a limb following amputation at or above the wrist or ankle joint.

#### Third Degree Burns

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area.

## 2 SEVERITY LEVELS

### How Is Severity Measured?

**Third Degree Burns:** Severity is measured from the Wallace 'rule of nine' which is the most common method for determining burn percentage. This method divides the body surface into areas each representing nine per cent of total body surface area. Adding up the injured areas provides an assessment of burn percentage.

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

#### Severity Level A:

- Third degree burns
- Loss of hands or feet.

#### Severity Level B:

- Loss of a single limb
- Less extensive Third degree burns covering 15% of the body's surface area.

#### Severity Level C:

- Less extensive Third degree burns covering 10% of the body's surface area
- Loss of use of a whole hand
- Loss of a single hand or foot.

#### Severity Level D:

- Surgical Re-attachment of an Amputated Limb

#### Severity Level E:

- Le Fort III Reconstruction
- Less extensive Third Degree Burns covering 5% of the body's surface area.

#### Severity Level F:

- Amputation of two or more fingers or thumbs at the metacarpal bone

## 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Either or both of the following may apply to any claim under this category:

- Must be diagnosed and treated by an *appropriate medical specialist*.
- Appropriate investigations and reports must be available.

## 4 SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the

Definitions section of this illness category, or not meeting the stated minimum required severity.

- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*

## 1.j Eye to Age 70 category – specified conditions of defined severity

### 1 DEFINITIONS

#### Blindness

*Permanent and irreversible* loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

#### Blindness in one eye

Total *permanent and irreversible* loss of all sight in one eye.

#### Central Blindness

*Permanent and irreversible* loss of central vision of 20 degrees from the centre of the horizontal plane of the visual field. The measurement of this must be supervised by a Consultant Ophthalmologist.

#### Severe Visual Impairment

*Permanent and irreversible* reduction in the sight of both eyes such that the Snellen rating is less than 6/36 after correction.

#### Significant Visual Impairment

*Permanent and irreversible* reduction in the sight of both eyes such that the Snellen rating is less than 6/18 after correction.

#### Surgical Removal of one eye

Surgical removal of a complete eyeball for disease or trauma.

#### Surgical Repair of a Detached Retina

The surgical repair of a detached retina by a Consultant Ophthalmologist. Laser surgery is specifically excluded.

#### Tunnel Vision

*Permanent and irreversible* loss of peripheral vision such that the total field of vision is 90 degrees or less in the horizontal plane with both eyes open. The measurement of this must be supervised by a Consultant Ophthalmologist.

## 2 SEVERITY LEVELS

### How Is Severity Measured?

**Visual acuity:** The Snellen rating is the measurement of visual acuity using a standard Snellen chart at 6 metres. This must be supervised by a Consultant Ophthalmologist and reported as a fraction such as 6/18 or 6/36, meaning an individual can read at 6 metres letters that people with normal vision can read at 18 or 36 metres.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

#### Severity Level A:

- Blindness
- Severe Visual Impairment.

#### Severity Level C:

- Significant Visual Impairment

#### Severity Level D:

- Central Blindness

#### Severity Level E:

- Blindness in one Eye
- Tunnel Vision
- Surgical Removal of one Eye.

#### Severity Level F:

- Surgical repair of a detached retina

## 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Signs and symptoms must be compatible with the condition claimed.
- The Consultant Ophthalmologist's report must be available with details of corrected visual acuity.
- Relevant investigations must be performed.

## 4 SPECIFIC EXCLUSIONS

- Any condition stated in 1j) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner.
- Any temporary reduction in sight.
- If a Consultant considers that a device or implant could result in the improvement of sight.

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 1.k Ear to Age 70 category – specified conditions of defined severity

### 1 DEFINITIONS

#### Deafness

*Permanent and irreversible* loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

#### Radical Mastoid Surgery

The surgical drainage and excision of chronically infected bony tissue from the mastoid area of the skull. There must have been radiological proof of bony destruction of the mastoid bones by infection.

#### Significant Hearing Loss in Both Ears

*Permanent and irreversible* loss of hearing to the extent that the loss is greater than 70 decibels across all frequencies in the better ear using a pure tone audiogram. There should be at least two measurements over a period of six months in order for a claim to be considered

## 2 SEVERITY LEVELS

### How Is Severity Measured?

**Hearing loss:** Severity is measured according to the latest version of the British Society of Audiology guidelines for Audiometry. The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

#### Severity Level A:

- Deafness

#### Severity Level C:

- Significant hearing loss in both ears

#### Severity Level F:

- Radical Mastoid Surgery

### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant investigations and reports must be available.
- Must be diagnosed and treated by an *appropriate medical specialist*.
- Must have relevant signs and symptoms.

### 4 SPECIFIC EXCLUSIONS

- Any condition stated in 1k) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 1.1 Endocrine and Metabolic Diseases category – specified conditions of defined severity

### 1 DEFINITIONS

The following conditions are covered (only one payment will be made for each):

#### Acromegaly

A disease of the pituitary gland with production of excess growth hormone which cannot be suppressed below 2 ng/ml after a 75 Gram oral glucose load.

#### Addison's Disease

Primary Adrenal insufficiency is a disease in an individual who has never taken steroids without pituitary disease. There must be low levels of circulating steroids and high levels of Adrenocorticotrophic hormone. This must be present for at least six months.

#### Adrenalectomy

The therapeutic surgical removal of the complete adrenal gland for documented disease

#### Conn's Syndrome

A disease of the adrenal glands with persistently raised aldosterone levels and reduced rennin levels. There must be evidence of low serum levels of potassium of less than 3 Mmol/L, rennin levels of less than 1ng/ml/Hr and a plasma aldosterone level of greater than 15 nG/dl.

#### Cushing's Syndrome

A disease in an individual who has never taken steroids with raised cortisol on 24 hour urine collection and confirmatory testing such as dexamethasone test or imaging of the adrenal and/or pituitary glands. This must be present for at least six months.

#### Diabetes Insipidus

The *permanent* inability of the body to concentrate urine. This must be *permanent* and be caused by either the lack of the hormone vasopressin to be secreted or the failure of the kidney to respond to vasopressin. This is not Diabetes Mellitus (Sugar Diabetes).

#### Insulinoma

A tumour of the pancreas producing high levels of insulin causing recurrent attacks of hypoglycaemia. The insulinoma must be diagnosed by MRI or CT scan.

#### Pheochromocytoma

A tumour of the adrenal gland producing high levels of adrenal hormones. The secretion can be demonstrated by high levels of urinary vanillyl mandelic acid and is associated with a compatible complication such as raised blood pressure.

#### Radiotherapy to the Pituitary Gland

Radiotherapy to the pituitary gland for the treatment of a documented pituitary adenoma.

#### Sheehan's Syndrome

Evidenced by radiological evidence of infarction of the pituitary gland, a serum prolactin of less than 5 ng per ml and evidence of failure of the pituitary to secrete other hormones.

#### Simmond's Disease

An *irreversible* failure of the pituitary to secrete normal levels of hormones. There must be all of the following: low T4 hormone levels, low T3 resin uptake, low testosterone levels and low prolactin levels. These must be present for at least six months and require replacement therapy.

#### Surgical Removal of the Pituitary Gland

The surgical removal of the pituitary gland for the treatment of a documented pituitary adenoma.

**Thyrotoxic Crisis**

A clinical condition in someone who has never taken thyroid hormones, with fever, rapid heart rate of over 130, delirium and coma. These symptoms must result in admission to hospital for at least seven days. There must be recorded levels of circulating thyroid hormones at least three times the normal level.

**2 SEVERITY LEVELS**

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

**Severity Level E:**

- Diabetes Insipidus
- Sheehan's Syndrome
- Thyrotoxic Crisis.

**Severity Level F:**

- Conn's Syndrome
- Cushing's Syndrome
- Addison's Disease
- Pheochromocytoma
- Surgical Removal of the Pituitary Gland
- Radiotherapy to the Pituitary Gland
- Insulinoma
- Simmond's Disease
- Adrenalectomy
- Acromegaly.

**3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM**

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant signs and symptoms must be present compatible with the condition claimed.
- Investigations must be available.
- Diagnosis and treatment must be by an *appropriate medical specialist*.

**4 SPECIFIC EXCLUSIONS**

- Any claim for Insulin or Non-Insulin Diabetes Mellitus (Sugar Diabetes).
- Any second claim at any time under any of the illnesses listed above in provision 1 l) i.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).

- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

**1.m Major Organ Transplant category****1 DEFINITIONS****Major Organ Transplant**

The undergoing as a recipient of a transplant of bone marrow or of a complete heart, kidney, liver, lung, or pancreas, or inclusion on an official UK waiting list for such a procedure. For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

Only one procedure is covered for transplants of the heart and/or both lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.

**2 SEVERITY LEVELS****Severity Level A:**

- Major Organ Transplant

**3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM**

This should be read in addition to and in connection with provision B2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Appropriate signs and symptoms compatible with the condition claimed;
- must be diagnosed and treated by an *appropriate medical specialist*;
- relevant investigation results and any other supporting specialist reports required;
- histology report must be available if needed.

**4 SPECIFIC EXCLUSIONS**

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 1.n Permanent Disability

### 1 DEFINITIONS

#### Cauda Equina

The compression of the nerve roots in the lumbar spine causing the loss of sensation and movement to the bladder, bowel and both legs. The disability must be *permanent* and supported by appropriate neurological evidence.

#### Mental and Behavioural Disorder: Persistent Confusional State to age 70

An individual shall be considered to be in a persistent confusional state where the individual cannot:

- i) Follow simple instructions;
- ii) perform simple daily tasks including eating, drinking and washing; and
- iii) have any insight into his or her disability;

AND

A Court Order has been made in respect of the individual as a result of the individual being incapable by reason of mental disorder of managing and administering his or her property and affairs and that Court Order remains in force.

#### Mental and Behavioural Disorder: Total Lack of Social Interaction to age 70

An individual shall be considered to have a total lack of social interaction where the individual has:

- Ongoing medical treatment from a psychiatrist for more than two years,
- and more than two in-patient admissions, each greater than one week,
- and total lack of social interaction of any kind,
- and the *permanent* inability to carry out all of the following:
  - Answering the telephone;
  - holding a face to face conversation for at least five minutes;
  - travelling fifty metres outside using all available aids.

#### Total and Permanent Disability

The *plan schedule* states which of the following definitions (a) or (b) will apply in determining whether a *serious illness* exists under Total and Permanent Disability:

##### a) Total and Permanent Disability (own occupation) to age 70

Total and Permanent Disability (*own occupation*) pays out 100% once it is established to our satisfaction that the insured is totally and

*permanently* unable, as a result of illness or injury, to engage for profit or reward in their own occupation.

or

Pays out 50% on confirmation by a Consultant Physician of the insured's ongoing inability to perform, without the help of another person but with the use of appropriate devices, at least 2 *functional activity tests*.

If the insured is not engaged in a remunerative *occupation* immediately prior to the start of that illness or injury the definition set out at b) below shall apply in determining whether or not a *serious illness* exists under Total and Permanent Disability. When Total and Permanent Disability (*own occupation*) to age 70 is attached to a *whole of life plan*, the definition for Total and Permanent Disability will be converted to definition b) below when the insured attains age 70.

##### b) Total and Permanent Disability (Permanent Failure of Functional Activity)

Total and Permanent Disability (*Permanent Failure of Functional Activity*) pays out 100% on confirmation by a Consultant Physician of the insured's ongoing inability to perform, without the help of another person but with the use of appropriate devices, at least 4 of the 6 *functional activity tests*.

or

Pays out 50% on confirmation by a Consultant Physician of the insured's ongoing inability to perform, without the help of another person but with the use of appropriate devices, at least 2 of the 6 *functional activity tests*.

### 2 SEVERITY LEVELS

#### How is severity measured for permanent failure of functional activity within total and permanent disability?

The severity of a condition claimed under this *benefit* will be determined by the *permanent* inability to perform a number of *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*.

If you are aged 65 or over at the time of a claim we will assess a claim on the failure to perform a number of *activities of daily living* (ADL's).

If, however you are aged between 16 and 65 at the time of the claim, we will also consider whether the incapacity resulting from your *life-changing event* causes an inability to perform any *activities of daily work* (ADW). Assessment of your claim will only be made on one group of *functional activity tests*,

either *activities of daily work* (ADW) or *activities of daily living* (ADL). Please note that there will be no accumulation of an inability to perform ADLs and ADWs when counting the number of failures of tasks but we will use the set of *functional activity tests* most favourable to *you*. See provision D5.4 for full details of these *functional activity tests*.

#### Severity Level A:

- Cauda Equina
- Mental and Behavioural Disorder - Persistent Confusional State to age 70
- Mental and Behavioural Disorder - Total Lack of Social Interaction to age 70
- Total and Permanent Disability – *own occupation*
- Total and Permanent Disability - *permanent* failure of 4 from 6 functional activity tests.

#### Severity Level C:

- Total and Permanent Disability – *permanent* failure of 2 from 6 *functional activity tests*.

### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision B2.1 and D5.

Any of the following may apply to any claim under this category:

- Must be diagnosed and treated by an *appropriate medical specialist*
- Relevant investigations and reports must be available
- Signs and symptoms must be compatible with the condition claimed.

In order for a Total and Permanent Disability claim to be paid, we will require that the extent of permanency has been established to *our* satisfaction.

### 4 SPECIFIC EXCLUSIONS

- Any condition stated in 1n) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 2 Appendix

### Disability Cover Illnesses and Conditions.

Illnesses and Conditions – Definitions for Disability Cover (see provision C2).

#### 1.a Advanced Cancer category – specified conditions of defined severity.

##### 1 DEFINITIONS

###### Advanced aplastic anaemia

Aplastic anaemia is the reduction of circulating red cells, white cells and platelets. For the purposes of this *plan* pancytopenia causing a reduction to 10% of the normal number of white cells and platelets as well as 50% of the normal levels of red cells, must be present. All lines of blood production must be depressed as demonstrated by bone marrow examination and abnormalities persisting on blood tests for a minimum of three months.

###### Advanced Cancer

An advanced malignant tumour that has progressed to at least Group Stage III of the TNM Classification of Malignant Tumours as described in the 6th edition of the International Union against Cancer (pub.Wiley-Liss).

###### Advanced Chronic Lymphocytic Leukaemia

For the purpose of this *plan* leukaemia means a disease of a single clone-line of white blood cells. There must be widespread uncontrolled growth of malignant white blood cells. There must also be evidence of replacement of the normal bone marrow by abnormal white cells with immature blast cells in the peripheral blood.

Chronic Lymphocytic Leukaemia is covered when it has progressed to Binet Stage C.

###### Advanced Hodgkin's Disease

This is an advanced malignant condition of the reticulo-endothelial system, which includes the lymph nodes, spleen and liver characterised by Reed-Sternberg cells in the abnormal lymph tissue. The staging must have progressed to at least Stage III of the Ann-Arbor system.

###### Advanced Non-Hodgkin's Lymphoma

This is an advanced malignant condition of the reticulo-endothelial system, which includes the lymph nodes, spleen and liver. The staging must have progressed to at least Stage III of the Ann-Arbor system.

###### Bone Marrow Transplant

The undergoing as a recipient of a transplant of bone marrow or inclusion on an official *UK* waiting list for such a procedure. For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

###### Leukaemia

For the purpose of this *plan* leukaemia means a disease of a single clone-line of white blood cells. There must be widespread uncontrolled growth of malignant white blood cells. There must also be evidence of replacement of the normal bone marrow by abnormal white cells with immature blast cells in the peripheral blood. Acute leukaemias and Chronic Myeloid Leukaemia are covered under this *benefit*.

## 2 CATEGORY LEVELS

### Category Level A:

- Advanced cancer classified as a TNM Group Stage III tumour or above
- Advanced Hodgkin's Disease classified as Ann-Arbor Stage III or above
- Advanced Non-Hodgkin's Lymphoma classified as Ann-Arbor Stage III or above
- Acute Myeloid Leukaemia
- Advanced Chronic Lymphocytic Leukaemia classified as Binet Stage C
- Chronic Myeloid Leukaemia
- Acute Lymphoblastic Leukaemia
- Bone marrow transplant as a recipient
- Inclusion on an official *UK* waiting list for the transplantation of bone marrow
- Advanced Aplastic Anaemia.

## 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Copies of the histology and staging reports of the tissue removed or biopsied. Serum markers or radiological evidence alone are not acceptable for the diagnosis of cancer under the terms of this *plan*.
- Confirmation of the diagnosis by an *appropriate medical specialist* and copies of the specialist and hospital reports.
- Relevant CT/MRI scans, bone marrow histology and Full Blood Count results where appropriate.

## 4 SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 2 Appendix Cardiovascular System

### 1.b Cardiovascular System category – specified conditions of defined severity

#### 1 DEFINITIONS

##### Any Cardiac Condition resulting in a Reduced Ejection Fraction

Any cardiac condition causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 39% or less. There must be two measurements with an interval of at least six months for a claim to be considered.

##### Cardiomyopathy resulting in a Reduced Ejection Fraction

A disease of the heart muscle causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 39% or less. There must be two measurements with an interval of at least six months for a claim to be considered. Alcoholic cardiomyopathy is specifically excluded.

##### Congestive Heart Failure

The inability of the heart muscle on either the right or left side of the heart, or both, to pump blood effectively resulting in a backflow into vessels supplying the heart. For the purposes of this *plan* this must be diagnosed by a Consultant Cardiologist and *optimal therapy* must have been established for at least six months. There must be at least three signs of congestive heart failure present for a claim to be considered.

The signs of congestive heart failure include:

- Presence of third heart sound
- jugular venous pressure above 6 cms
- rales present in both bases on auscultation
- cardiomegaly on chest x-ray

- grade 3, or gross ascites, associated with marked abdominal distension – severe oedema to a level above the knee.

##### Heart Attack resulting in a Reduced Ejection Fraction

A heart attack causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 39% or less. The measurement must be performed at least one month after an acute heart attack.

##### Heart Transplant

The undergoing as a recipient of a transplant of a complete heart or a heart and lung, or inclusion on an official *UK* waiting list for such a procedure. For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

Only one procedure is covered for transplants of the heart and/or both lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.

##### Severe Peripheral Vascular Disease

There must be severe restriction of blood flow through the arteries below the knee as measured by doppler readings of less than 30 per cent of normal and a claudication distance of 20 metres. Surgery must have failed to reverse this or be contraindicated for reasons as agreed by *our* Chief Medical Officer.

##### Severe Vascular Disease affecting Multiple Systems

Severe vascular disease affecting the heart, kidney and/or brain. There must be at least two of the following:

- Stroke\*;
- left ventricular hypertrophy measured by a ratio of the thickness of the septal wall to the posterior left ventricular wall of 1:1.3;
- renal dysfunction measured by blood urea greater than 15mmol/l and serum creatinine greater than 200mmol/l;
- grade 4 retinopathy; combined with an elevated blood pressure with a diastolic reading i.e. pressure in the left ventricle during the resting phase, as specified in Category Levels A and B below.

\*For the purposes of this *plan* a stroke is an acute event, requiring admission to hospital, as diagnosed by a Consultant Neurologist or stroke physician. There must be residual deficit with a Modified Rankin Scale of 2 or above.

## 2 CATEGORY LEVELS

### How is severity measured?

**Reduction in ejection fraction:** The ejection fraction is a measure of the efficiency of the pumping action of the heart; in a healthy heart this is typically greater than 50%. Damage to the muscle of the heart (myocardium) such as that sustained during myocardial infarction or cardiomyopathy, impairs the heart's ability to eject blood and therefore reduces ejection fraction. Where a severity is measured by the *permanent* reduction in ejection fraction it is measured by the percentage of the contents of the left ventricle that is expelled in each contraction of the ventricle. This can be measured by echocardiography or through radioisotope measurements. It must be measured in a cardiac laboratory, which has regular quality control audits available to us, and be supervised by a Consultant Cardiologist.

The disease or disorder causing the reduction in ejection fraction must be established as being *permanent* and *irreversible* and the measurement must be taken whilst the patient is on optimal treatment.

**Stroke:** Severity is measured by the Modified Rankin Scale (van Swieten et al., 1988). This is an internationally accepted measure of disability for neurological conditions, especially stroke. It is scored from 0 to 5, with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

**Congestive heart failure:** Severity is measured by presence of at least three signs of congestive heart failure.

#### Category Level A:

- Cardiomyopathy resulting in a *permanent* ejection fraction of 29% or less whilst on *optimal therapy*.
- Heart attack resulting in a *permanent* ejection fraction of 29% or less whilst on *optimal therapy*.
- Any other cardiac condition resulting in a *permanent* ejection fraction of 29% or less whilst on *optimal therapy*.
- Heart, or heart and lung transplant.
- Inclusion on an official UK waiting list for the transplantation of a heart, or a heart and lung transplant.
- At least four signs of congestive heart failure on *optimal therapy* for at least six months.
- Severe vascular disease affecting multiple systems with a diastolic blood pressure greater than 110mmHg on *optimal therapy*.
- Severe peripheral vascular disease.

#### Category Level B:

- Cardiomyopathy resulting in a *permanent* ejection fraction of between 30% and 39% whilst on *optimal therapy*.
- Heart attack resulting in a *permanent* ejection fraction of between 30% and 39% whilst on *optimal therapy*.
- Any other cardiac condition resulting in a *permanent* ejection fraction of between 30% and 39% whilst on *optimal therapy*.
- At least three signs of congestive heart failure on *optimal therapy* for at least six months.
- Severe vascular disease affecting multiple systems with a diastolic blood pressure greater than 100mmHg on *optimal therapy*.

### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Full cardiologist's, cardiothoracic, neurosurgeon or vascular surgeon's assessment and operation notes;
- relevant electrocardiographs, angiograms, aortograms, thallium scans, echocardiograms, X-rays, CT scans or any other relevant test results and reports;
- cardiac enzyme results for heart attacks. Raised serum CKMB fraction or positive Troponin-T or I, if performed. Raised creatinine kinase and LDH alone are not considered;
- history of signs and symptoms compatible with the condition.

### 4 SPECIFIC EXCLUSIONS

- Any Acute coronary syndromes which do not completely satisfy any of the above definitions including, but not limited to, angina.
- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.
- Alcoholic Cardiomyopathy.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to your *plan*.

## 2 Appendix Digestive System

### 1.c Digestive System category – specified conditions of defined severity

#### 1 DEFINITIONS

##### **Fulminant Hepatic Necrosis**

Massive necrosis (death of liver tissue) with clotting deficiencies and metabolic abnormalities which cause coma occurring in an individual without any previous liver disease. There must be jaundice, encephalopathy and admission to a specialist liver unit.

##### **Liver Transplant**

The undergoing as a recipient of a transplant of a complete liver or inclusion on an official *UK* waiting list for such a procedure.

For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

If, in the opinion of *our* Chief Medical Officer, *alcohol or drug abuse* is a significant contributing factor as a cause of liver disease necessitating a transplant, the claim will be declined.

##### **Pancreas Transplant**

The undergoing as a recipient of a transplant of a complete pancreas or inclusion on an official *UK* waiting list for such a procedure.

For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

If, on the balance of probabilities, *alcohol or drug abuse* is a significant contributing factor as a cause of pancreatic disease necessitating a transplant, the claim will be declined.

##### **Permanent Faecal Incontinence**

There must be *permanent* incontinence of faeces with constant soiling, despite *optimal therapy*, for a period of one year. This must require daily pads as prescribed by a consultant physician or surgeon.

##### **Severe Cirrhosis of the Liver**

A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy.

To be considered as severe the following must be present for at least one year and there must be all of the following throughout this period:

- Persistent jaundice marked by elevated bilirubin levels above 50 micromols/litre, and abnormal protein production marked by decreased albumin levels below 27 G/L, and
- abnormal clotting of the blood marked by a Prothrombin time above two times the normal limit or an International Normalisation Ratio (INR) above 2.0.

If, in the opinion of *our* Chief Medical Officer, *alcohol or drug abuse* is a significant contributing factor as a cause of severe cirrhosis of the liver, the claim will be declined.

##### **Severe Inflammatory Crohn's Disease**

A definite diagnosis of Crohn's Disease by a Consultant Gastroenterologist. To be considered as severe, symptoms must not have responded to *optimal therapy* while under the continued supervision of a Gastroenterologist. There must also be evidence of continued inflammation with all of the following having occurred:

- Stricture formation causing intestinal obstruction requiring admission to hospital, and
- Fistula formation between loops of bowel or bowel to another organ, and
- At least one resection of a segment of small bowel

## 2 CATEGORY LEVELS

### Category Level A:

- Fulminant Hepatic Necrosis
- Severe Cirrhosis of the Liver
- Transplantation of a liver
- Inclusion on an official *UK* waiting list for the transplantation of a liver
- Transplantation of a pancreas
- Inclusion on an official *UK* waiting list for the transplantation of a pancreas
- *Permanent* faecal incontinence.

### Category Level B:

- Severe Inflammatory Crohn's disease

## 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Diagnosis and treatment by an appropriate medical specialist.
- Relevant investigations, results, copies of hospital and histology reports signed by a suitably qualified Consultant Histopathologist.
- Appropriate signs and symptoms compatible with the condition claimed.

#### 4 SPECIFIC EXCLUSIONS

- *Alcohol or drug abuse.*
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 2 Appendix Mental Behaviour & Behaviour Disorders

### 1.d Mental and Behavioural Disorders category – specified conditions of defined severity

#### 1 DEFINITIONS

##### Legally institutionalised

Compulsory admission under the Mental Health Act, 1983. There must be ongoing medical treatment from a psychiatrist for more than two years.

##### Persistent Confusional State

An individual shall be considered to be in a persistent confusional state where the individual cannot:

- (i) Follow simple instructions;
- (ii) perform simple daily tasks including eating, drinking and washing; and
- (iii) have any insight into his or her disability; and a Court Order has been made in respect of the individual as a result of the individual being incapable by reason of mental disorder of managing and administering his or her property and affairs and that Court Order remains in force.

#### Total lack of Social Interaction

An individual shall be considered to have a total lack of social interaction where the individual has:

- Ongoing medical treatment from a psychiatrist for more than two years; and more than two in-patient admissions, each greater than one week; and total lack of social interaction of any kind; and
- the *permanent* inability to carry out all of the following:
  - Answering the telephone;
  - holding a face-to-face conversation for at least five minutes, and
  - travelling fifty metres outside using all available aids.

#### 2 CATEGORY LEVELS

##### Category Level A:

- Persistent confusional state
- Total lack of Social Interaction.

##### Category Level B:

- Legally institutionalised

#### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Diagnosis and treatment by an appropriate medical specialist
- Copies of all available specialist reports.

#### 4 SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 2 Appendix Musculoskeletal system

### 1.e Musculoskeletal System category – specified conditions of defined severity

#### 1 DEFINITIONS

##### **Cauda Equina**

The compression of the nerve roots in the lumbar spine causing the loss of sensation and movement to the bladder, bowel and both legs. The disability must be *permanent* and supported by appropriate neurological evidence.

##### **Connective Tissue Diseases**

Connective tissue diseases are a group of autoimmune diseases, which means that the body attacks itself, especially joints, blood vessels, kidneys, lungs and other organs. Connective tissue diseases are specifically diagnosed by certain criteria and for the purposes of this *plan* only the following diseases will be covered: giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosus, systemic sclerosis (scleroderma) and Wegener's granulomatosis. The full definitions for these are listed below.

Other diseases such as sero-negative arthritis, psoriatic arthritis or osteoarthritis are not covered.

##### **Giant Cell Arteritis**

The definite diagnosis of Giant Cell Arteritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

##### **Polyarteritis Nodosa**

The definite diagnosis of Polyarteritis Nodosa by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

##### **Polymyositis**

Polymyositis is an inflammatory disease affecting the muscles of the limbs especially the larger muscles. For the purpose of this *plan* there must be all of the following:

- Elevated serum muscle enzymes (CK, aldolase);
- Electromyographic findings typical of dermatomyositis (DM) or polymyositis (PM);

- Muscle biopsy findings typical of PM or DM (as defined above); and
- Compatible weakness – symmetrical proximal muscle weakness for which there is no other explanation. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

##### **Rheumatoid Arthritis**

The definite diagnosis of Rheumatoid Arthritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

##### **Systemic Lupus Erythematosus (SLE)**

The definite diagnosis of Systemic Lupus Erythematosus (SLE) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

##### **Systemic Sclerosis (Scleroderma)**

The definite diagnosis of Systemic Sclerosis (Scleroderma) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

##### **Wegener's Granulomatosis**

The definite diagnosis of Wegener's Granulomatosis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases. See 'How is severity measured?' in 1 e) 2 below for the assessment criteria.

##### **Less Extensive Third Degree Burns**

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 10% of the body's surface area.

##### **Loss of a single hand or foot**

*Permanent* physical severance of either hand or either foot at or above the wrist or ankle joint.

##### **Loss of a single limb**

*Permanent* physical severance of a single limb from above the knee or elbow joint.

##### **Loss of hands or feet**

*Permanent* physical severance of any combination of two or more hands or feet at or above the wrist or ankle joints.

### Radiculopathy and Significant Extremity Impairment

A disease of the spinal nerve roots resulting in significant impairment of the nerves in the legs.

There must be all of the following:

- Muscle biopsy findings typical of PM or DM Loss of the ability to raise the affected leg straight to more than 30 degrees;
- Muscle biopsy findings typical of PM or DM atrophy of affected muscles;
- Muscle biopsy findings typical of PM or DM loss of reflexes, and
- Muscle biopsy findings typical of PM or DM numbness (loss of all sensation of touch and pinprick) in the corresponding dermatome.

The disability must be *permanent* and supported by appropriate neurological evidence.

#### Third Degree Burns

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area.

Adding up the injured areas provides an assessment of burn percentage.

#### Category Level A:

- Third degree burns covering at least 20% of the body's surface area
- Loss of Hands or Feet
- Cauda Equina
- Connective Tissue Diseases causing the *permanent* inability to perform at least four out of six *functional activity tests*. See provision D5.4.

#### Category Level B:

- Less extensive third degree burns covering at least 10% of the body's surface area.
- Loss of a single hand or foot.
- Loss of a single limb.
- Connective Tissue Diseases causing the *permanent* inability to perform at least two out of six *functional activity tests*. See provision D5.4.
- Radiculopathy and significant extremity impairment.

### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Must be diagnosed and treated by an *appropriate medical specialist*.
- Appropriate investigations and reports must be available.

### 4 SPECIFIC EXCLUSIONS

- Fibromyalgia, or any synonym including, but not limited to, fibromyositis, fibrositis, muscular rheumatism, myofascial pain syndrome.
- Osteoarthritis, wear and tear or any other subjective, non-diagnosed condition.
- Chronic fatigue syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free disease.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 2 CATEGORY LEVELS

### How is severity measured?

**Connective Tissue Diseases:** For the purposes of this *plan* the severity of Connective Tissue Diseases will be determined by the *permanent* inability to perform a number of *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*. If you are aged 65 or over at the time of a claim we will assess the claim on the failure to perform a number of *activities of daily living* (ADLs). The severity of the *benefit* increases should you become increasingly unable to perform more ADLs. If, however, you are aged between 16 and 65 at the time of the claim, we will also consider whether the incapacity resulting from *your life-changing event* causes an inability to perform any *activities of daily work*. Assessment of *your claim* will only be made on one group of *functional activity tests*, either *activities of daily work* (ADW) or *activities of daily living* (ADL). Please note that there will be no accumulation of an inability to perform ADLs and ADWs when counting the number of failures of tasks but we will use the set of *functional activity tests* most favourable to you. See provision D5.4 for full details of these *functional activity tests*.

**Third Degree Burns:** Severity is measured from the Wallace 'rule of nine' which is the most common method for determining burn percentage. This method divides the body surface into areas each representing nine per cent of total body surface area.

## 2 Appendix Nervous System

### 1.f Nervous System category – specified conditions of defined severity

#### 1 DEFINITIONS

##### **Bilateral Hemianopia**

*Permanent and irreversible* loss of vision in one half of the visual field of both eyes.

##### **Blindness**

*Permanent and irreversible* loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

##### **Deafness**

*Permanent and irreversible* loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

##### **Dementia**

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember;
- reason; and
- perceive, understand, express and give effect to ideas.

##### **Loss of Eye-Hand Co-ordination**

Total and *irreversible* loss of all eye-hand coordination such that the subject is incapable of being able to do all of the following:

- Write;
- feed by bringing a fork or spoon to mouth, and
- drink unaided from a cup, glass or mug.

##### **Loss of Manual Dexterity**

Total and *irreversible* loss of the ability to use the hands and fingers with precision to perform daily activities of work such as picking up or manipulating small objects, operating a range of equipment manually or communicating through writing or typing. The disability must be *permanent* and supported by appropriate neurological evidence.

##### **Loss of Muscle Power resulting in the inability to grip**

Total and *irreversible* loss of all muscle power in both hands resulting in the inability to grip any tool, utensil or assistive device. The disability must be *permanent* and supported by

appropriate neurological evidence.

##### **Loss of Use of a Leg**

Total and *irreversible* loss of muscle function or sensation to the whole of a leg as a result of injury or disease. The disability must be *permanent* and supported by appropriate neurological evidence.

##### **Loss of Use of a Whole Hand**

Total and *irreversible* loss of muscle function or sensation to the whole of a hand as a result of injury or disease. The disability must be *permanent* and supported by appropriate neurological evidence.

##### **Neurological Diseases**

Several neurological diseases not specifically stated under this *benefit* can still cause a significant impact to *your* daily activities. To cover these conditions we will pay a *benefit* if *you* become *permanently* unable to perform certain *functional activity tests* due to a neurological disease. The neurological system comprises the system of cells, tissues and organs that regulate the body's responses to internal and external stimuli and consists of the brain, spinal cord, nerves, ganglia and parts of the receptor and effector organs. See provision D5.4 for full details of these *functional activity tests*.

##### **Paralysis of Limbs**

Total and *irreversible* loss of muscle function to the whole of any two limbs.

##### **Persistent Disabling Monoplegia**

Total and *irreversible* loss of muscle function or sensation to the whole of one arm or leg as a result of injury or disease. The disability must be *permanent* and supported by appropriate neurological evidence.

##### **Persistent Vegetative State**

A severe neurological condition of decreased consciousness where there must be all of the following:

- The loss of an awareness of surroundings;
- the lack of speech;
- the lack of response to commands; and
- the lack of any purposeful movements.

This condition must be *permanent* and supported by appropriate neurological evidence.

##### **Severe Visual Impairment**

*Permanent and irreversible* reduction in the sight of both eyes such that the Snellen rating is less than 6/36, after correction in the better eye.

**Significant Hearing Loss in Both Ears**

*Permanent* and *irreversible* loss of hearing to the extent that the loss is greater than 70 decibels across all frequencies in the better ear using a pure tone audiogram. There must be at least two measurements over a period of six months in order for a claim to be considered.

**Significant Visual Impairment**

*Permanent* and *irreversible* reduction in the sight of both eyes such that the Snellen rating is less than 6/18, after correction in the better eye.

**Stroke (with a residual deficit measuring 4 or above on the Modified Rankin Scale)**

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in *permanent* neurological deficit with persisting clinical symptoms. For the above definition, the following are not covered:

- Transient ischaemic attack
- Traumatic injury to brain tissue or blood vessels

**Total Aphasia**

The total lack of the ability to speak. The disability must be *permanent* and supported by appropriate neurological evidence.

Please note that there will be no accumulation of an inability to perform ADLs and ADWs when counting the number of failures of tasks but we will use the set of *functional activity tests* most favourable to you. See provision D5.4 for full details of these *functional activity tests*.

**Visual acuity:** The Snellen rating is the measurement of visual acuity using a standard Snellen chart at six metres. This should be supervised by a Consultant Ophthalmologist and reported as a fraction such as 6/18 or 6/36, meaning an individual can read at six metres letters that people with normal vision can read at 18 or 36 metres.

**Hearing loss:** Severity is measured according to the latest version of the British Society of Audiology guidelines for Audiometry.

**Category Level A:**

- Blindness\*
- Deafness\*
- Loss of manual dexterity
- Loss of muscle power resulting in the inability to grip
- Paralysis of limbs
- Persistent vegetative state
- Severe visual impairment\*
- Stroke (with a residual deficit measuring 4 or above on the Modified Rankin Scale)
- Any neurological disease causing the *permanent* inability to perform at least four out of six *functional activity tests* (FATs). See provision D5.4.

**Category Level B:**

- Dementia
- Loss of eye-hand co-ordination
- Loss of use of a leg
- Loss of use of a whole hand
- Bilateral hemianopia\*
- Persistent disabling monoplegia
- Significant hearing loss in both ears\*
- Significant visual impairment\*
- Total aphasia\*
- Any neurological disease causing the *permanent* inability to perform at least two out of six *functional activity tests* (FATs). See provision D5.4.

\*Hearing, speech and sight measurements are not limited to causes within the nervous system, but to any anatomical or functional impairment causing these outcomes. All measurements are with appropriate aids.

**2 CATEGORY LEVELS****How Is Severity Measured?**

**Modified Rankin Scale:** Severity of a stroke is measured by the Modified Rankin Scale (van Swieten et al., 1988). This is an internationally accepted measure of disability for neurological conditions, especially stroke. It is scored from 0 to 5, with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

**Neurological diseases:** The severity will be determined by the *permanent* inability to perform a number of *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*.

If *you* are aged 65 or over at the time of a claim we will assess the claim on the failure to perform a number of *activities of daily living* (ADL's). The severity of the *benefit* increases should *you* become increasingly unable to perform more ADL's.

If, however, *you* are aged between 16 and 65 at the time of the claim, we will also consider whether the incapacity resulting from *your life-changing event* causes an inability to perform any *activities of daily work*. Assessment of *your* claim will only be made on one group of *functional activity tests*, either *activities of daily work* (ADW) or *activities of daily living* (ADL).

### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Relevant investigations must be done and the results available, including CT scan or MRI imaging, or any other relevant investigation results.
- Diagnosis made by an appropriate medical specialist.
- Appropriate signs and symptoms must be present and compatible with the condition claimed.
- Loss of neurological function compatible with area of damage of the brain involved.

#### 4 SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 2 Appendix Renal Disease

### 1.g Renal Disease category – specified conditions of defined severity

#### 1 DEFINITIONS

##### Chronic Renal Impairment

The impairment in kidney function such that the estimated glomerular filtration rate is below 25 mls/litre/min/1.73 m<sup>2</sup> surface area persistently for a period of six months or more.

##### Kidney Failure

Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is necessary.

##### Kidney Transplant

The undergoing as a recipient of a transplant of a complete kidney or inclusion on an official *UK* waiting list for such a procedure.

For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

### 2 CATEGORY LEVELS

#### How is severity measured?

**Renal function:** Severity is measured by the estimated glomerular filtration rate. This is a measure of the efficiency of the kidneys as a filter.

#### Category Level A:

- Kidney failure
- Transplantation of a kidney as a recipient
- Inclusion on an official *UK* waiting list for the transplantation of a kidney, as a recipient

#### Category Level B:

- Chronic renal impairment

### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Diagnosis and treatment by an appropriate medical specialist.
- Copies of all available specialist reports.
- Details of current and historic renal function tests.
- Histology of biopsies and any other relevant investigations must be available.

#### 4 SPECIFIC EXCLUSIONS

- Kidney donation.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 2 Appendix Respiratory System

### 1.h Respiratory System category – specified conditions of defined severity

#### 1 DEFINITIONS

##### Chronic Obstructive Pulmonary Disease

A disease of the airways of the lung causing obstruction to the exhalation of air. There must be *permanent* and *irreversible* reduction of the

maximum volume of air expelled in one second (FEV1) of less than 50% of predicted. There must be *permanent* and *irreversible* obstruction to airflow demonstrated by a FEV1/FVC ratio of less than 50% and there must be less than 5% variation in three repeated measurements, (which must be performed under the direction of a specialist respiratory physician) whilst on *optimal therapy*. They must be measured in a respiratory laboratory which has regular quality control audits available to us. These measurements must be repeated after an interval of at least three months and must also satisfy the criteria mentioned above for a claim to be considered. Only the following severity is covered:

- Stage IV – where FEV1 is 30% or less of predicted.

When both chronic obstructive pulmonary disease and fibrotic lung disease co-exist, only one payment will be made for the condition which is at the highest severity level.

#### Cor Pulmonale

*Irreversible* right ventricular failure due to a lung disease producing raised pulmonary artery pressure (Pulmonary Hypertension). There must be evidence of raised pulmonary artery pressure of at least 30mmHG (mm of mercury) and there must also be right ventricular dilatation and hypertrophy on echocardiogram with characteristic ECG changes.

#### Fibrotic Lung Disease

For the purpose of this *plan* fibrotic lung disease is defined as one of the following only:

- Sarcoidosis
- Fibrosing Alveolitis
- Aspergilosis

These fibrotic lung diseases produce thickening and fibrosis of the finest membranes in the alveoli that allow transfer of oxygen into the blood stream.

These tests must be performed under the direction of a specialist respiratory physician whilst on *optimal therapy*. They must also be measured in a respiratory laboratory, which has regular quality control audits available to us, and be supervised by the treating specialist.

When both chronic obstructive pulmonary disease and fibrotic lung disease co-exist, only one payment will be made (for the condition which is at the highest severity level).

#### Lung Transplant

The undergoing as a recipient of a transplant of lung or a heart and lung, or inclusion on an official *UK* waiting list for such a procedure. For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells. Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.

#### Primary Pulmonary Hypertension

The presence of *irreversible* raised pressure in the pulmonary arteries. The measurement reported must be the average level measured by cardiac catheterisation and be at least 30mmHG (mm of mercury) at rest. There must also be right ventricular dilatation and hypertrophy on echocardiogram with characteristic ECG changes.

#### Removal of Two or more Lobes of the Lungs

The therapeutic surgical removal of two or more lobes of the lungs for documented disease or trauma.

## 2 CATEGORY LEVELS

### How is severity measured?

#### Chronic Obstructive Pulmonary Disease:

The severity is assessed by the measurement of:

1. Vital Capacity (VC). This is the maximum total volume of air that can be expelled from the lung after maximum inhalation.
2. The Forced Expiratory Volume 1 (FEV1). The maximum volume of air expelled in one second.
3. The ratio of the two measurements. Fibrotic Lung Disease: The severity is measured by the Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco), that is the measurement that reflects the transfer of gases across the membranes of the lung into the blood stream from the air. This can only be performed in a lung function laboratory. It is called the transfer factor.

#### Category Level A:

- Fibrotic lung disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 34% of predicted or less
- Lung, or Heart and Lung transplant
- Inclusion on an official *UK* waiting list for the transplantation of a lung, or a heart and lung
- Primary Pulmonary Hypertension
- Cor Pulmonale.

### Category Level B:

- Fibrotic lung disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 35% and 39% of predicted
- Stage IV Chronic Obstructive Pulmonary Disease
- Removal of two or more lobes of the lungs.

### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C2.1 and D5.

Any or all of the following may apply to any claim under this category:

- Must be diagnosed and treated by an *appropriate medical specialist*.
- Relevant pulmonary and cardiac investigations must be done and be available.
- Histology report must be available if needed.
- Appropriate signs and symptoms compatible with the condition being claimed.

### 4 SPECIFIC EXCLUSIONS

- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

## 2 Appendix Permanent Failure Of Functional Activity

### 1.i Permanent Failure of Functional Activity – meeting specified criteria

#### 1 DEFINITIONS

Any condition leading to the *permanent* failure to perform at least two *functional activity tests*.

## 2 CATEGORY LEVELS

### How is severity measured?

The severity of a condition claimed under this *benefit* will be determined by the *permanent* inability to perform a number *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*.

If *you* are aged 65 or over at the time of a claim we will assess the claim on the failure to perform a number of *activities of daily living* (ADLs). The severity of the *benefit* increases should *you* become increasingly unable to perform more ADLs.

If, however, *you* are aged between 16 and 65 at the time of the claim, we will also consider whether the Incapacity resulting from *your life-changing event* causes an inability to perform any *activities of daily work*. Assessment of *your* claim will only be made on one group of *functional activity tests*, either *activities of daily work* (ADW) or *activities of daily living* (ADL). Please note that there will be no accumulation of an inability to perform ADLs and ADWs when counting the number of failures of tasks but we will use the set of *functional activity tests* most favourable to *you*.

The *activities of daily living* are:

- **Continence**  
The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained.
- **Dressing**  
The ability to put on, take off, secure and unfasten all garments and, any braces, artificial limbs or other surgical appliances.
- **Feeding**  
The ability to feed oneself once food and drink have been prepared and made available.
- **Mobility**  
The ability to move from one room to another in the insured life's normal place of residence on the same floor, using any walking stick or frame, if required.
- **Transferring**  
The ability to move from a bed to an upright chair or wheelchair, and vice versa.
- **Washing**  
The ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained.

The *activities of daily work* are:

- **Walking**  
The ability to walk 200 metres on a level surface with a stick or other aid without stopping or severe discomfort.

- Lifting  
The ability to pick up a 1Kg object from table height with either hand and carry it for 5 metres.
- Using a pen, pencil or keyboard  
The ability to use a pen, pencil or keyboard with either hand using any reasonable aids.
- Hearing  
The ability to hear well enough, with hearing aids, to understand someone speaking in a common language in a normal voice in a quiet room.
- Speech  
The ability to be understood in a common language in a quiet room.
- Vision  
The ability to see well enough to read 16 point print using spectacles or other reasonable aids.

#### Category Level A:

- The *permanent* inability to perform at least four out of six *functional activity tests*. See provision D5.4.

#### Category Level B:

- The *permanent* inability to perform at least two out of six *functional activity tests*. See provision D5.4.

### 3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C2.1 and D5.

Any or all of the following may apply to any claim under this category:

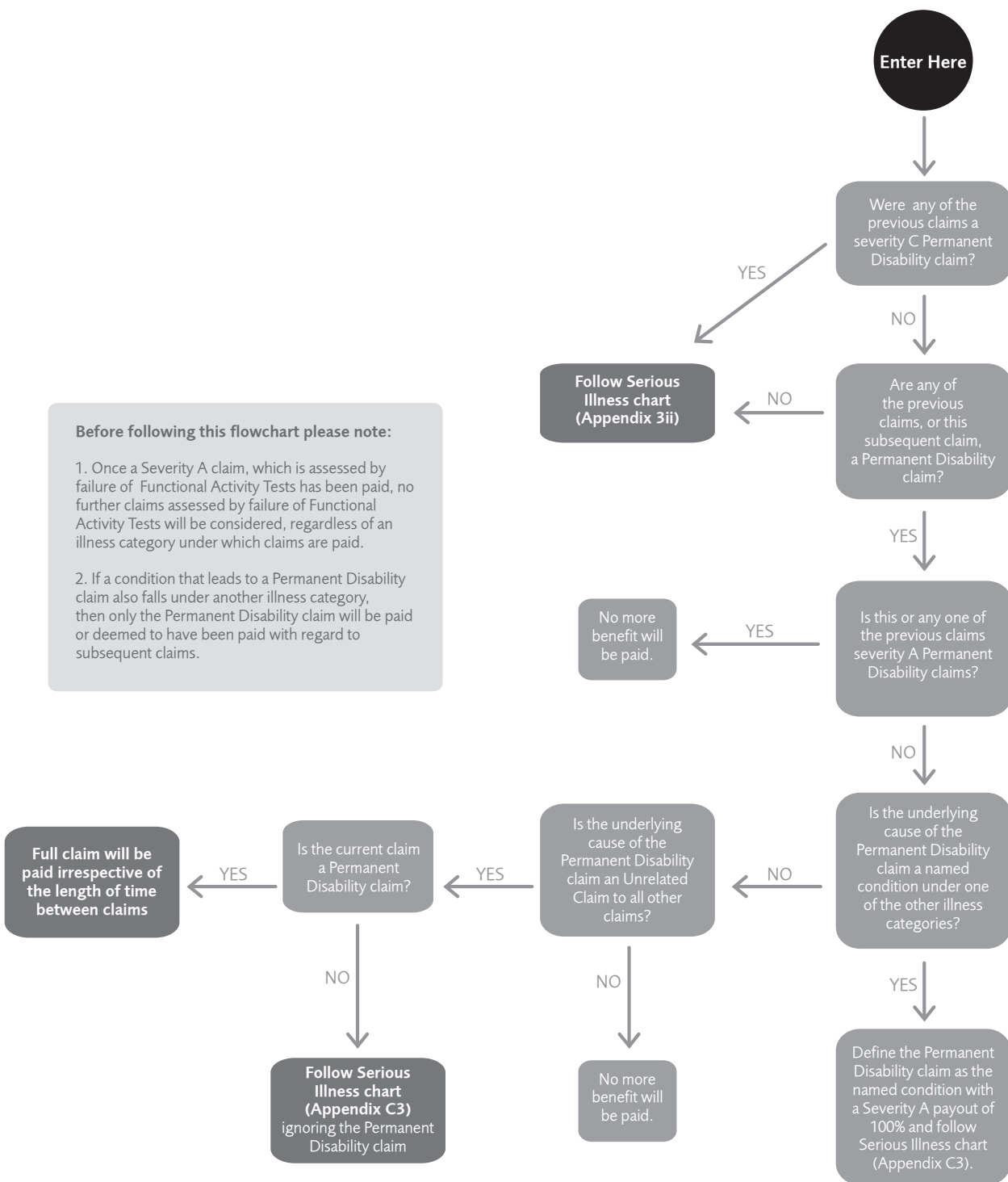
- Must be diagnosed and treated by an *appropriate medical specialist*.
- All relevant investigations must be done and the results available.
- All histology reports must be available if needed.
- Appropriate signs and symptoms compatible with the condition claimed.

### 4 SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity.
- Any cause of claim stated in provision D5.6 (Exclusions).
- Any exclusion contained within the definition of any named condition.
- Any exclusion applied specifically to *your plan*.

### 3 Appendix (i) - Subsequent Claims for Serious Illness Cover

#### ASSESSMENT OF SUBSEQUENT CLAIMS FOR PERMANENT DISABILITY

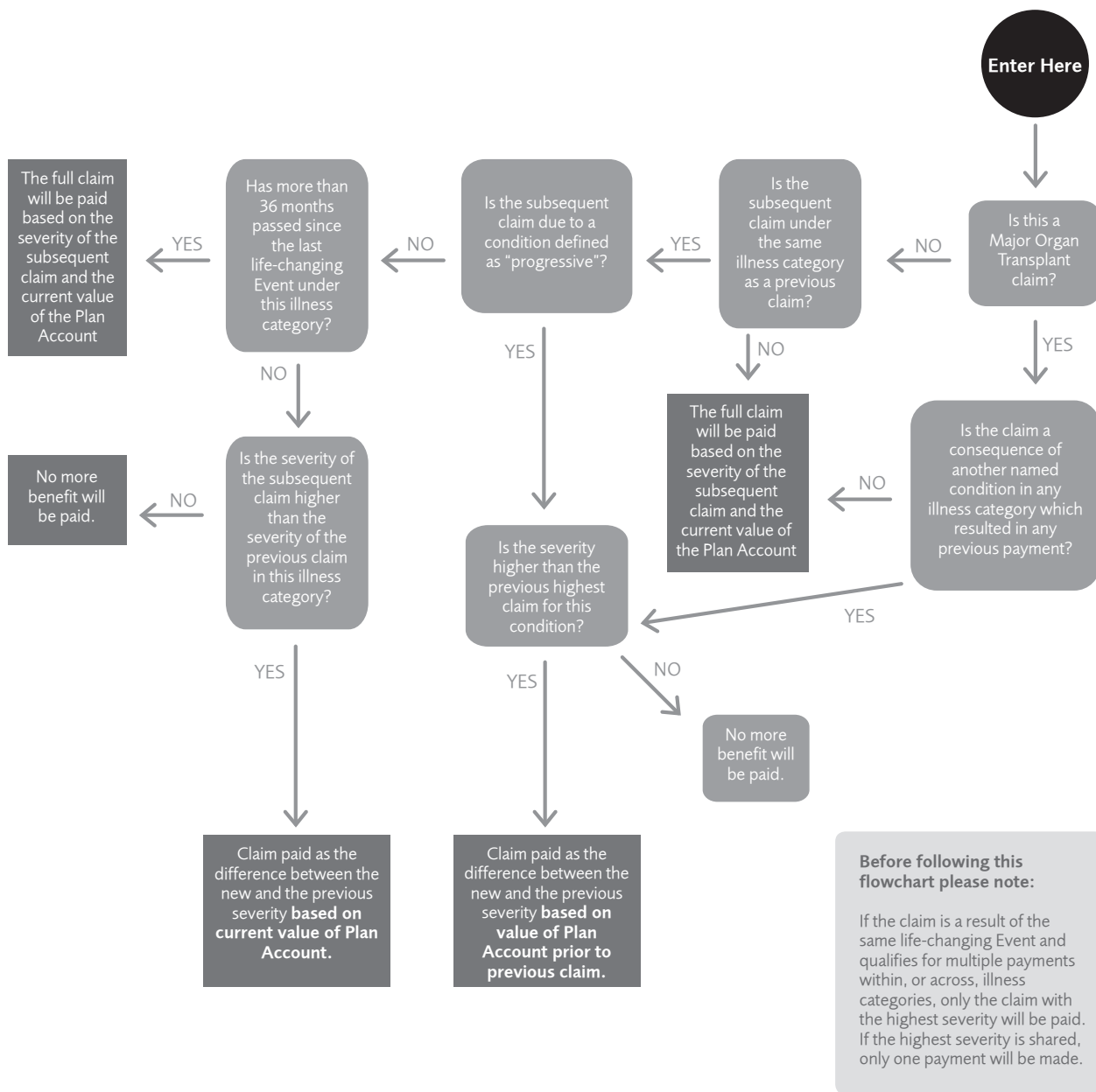


**Before following this flowchart please note:**

1. Once a Severity A claim, which is assessed by failure of Functional Activity Tests has been paid, no further claims assessed by failure of Functional Activity Tests will be considered, regardless of an illness category under which claims are paid.
2. If a condition that leads to a Permanent Disability claim also falls under another illness category, then only the Permanent Disability claim will be paid or deemed to have been paid with regard to subsequent claims.

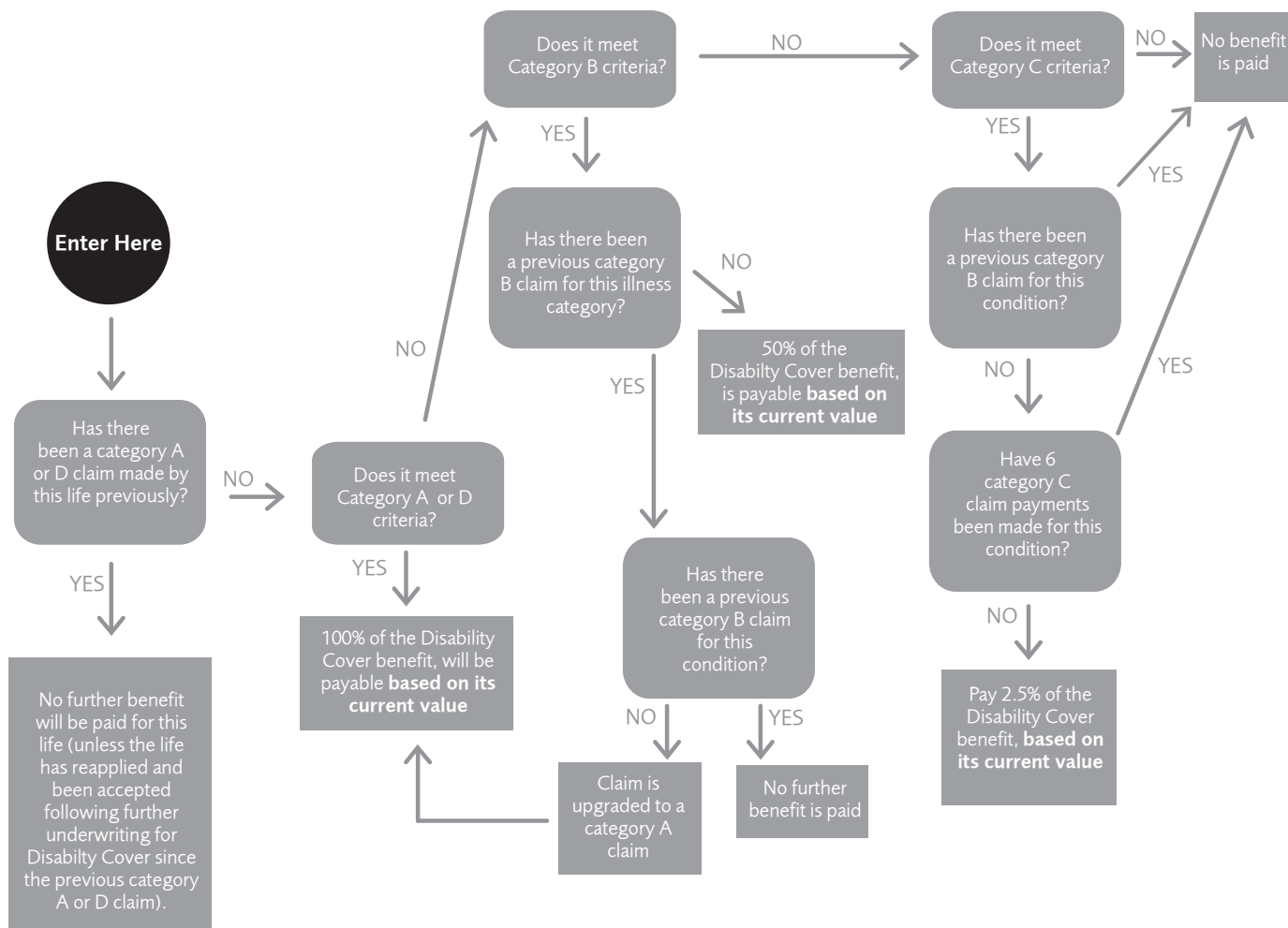
### 3 Appendix (ii) - Subsequent Claims for Serious Illness Cover

#### ASSESSMENT OF SUBSEQUENT PROGRESSIVE OR SUBSEQUENT UNRELATED SERIOUS ILLNESS COVER CLAIMS



## 4 Appendix - Subsequent Claims for Disability Cover

This is a visual aid overview. Other relevant information and full details of the exclusions can be found in C3 and D5.6 of these provisions.











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