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VitalityLife Essentials Plan Provisions.

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VITALITYLIFE
ESSENTIALS PLAN PROVISIONS

This document is *your plan* provisions. It explains how *your 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. It explains how taking steps to improve *your* health can reduce *your plan premium*.

If there is anything that is not clear, please speak to *your* financial adviser, if *you* have one. *You* can also email *us* at lifeenquiries@vitality.co.uk or call *us* on 0345 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 Vitality Life 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.

PLEASE CONTACT US ON 0345 601 0072
OR SPEAK TO YOUR ADVISER IF YOU WOULD LIKE THIS DOCUMENT IN LARGE PRINT OR BRAILLE.

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 *we* make payments to *you* as a result of a successful claim for Life Cover or Serious Illness Cover, 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 Protected Life Cover and the Protected Life and Serious Illness Cover options in provision C9.

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' overleaf.

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 *plan account* is designed to stay the same over the life of the *plan*. It will only change if something happens such as *you* make a claim or change a cover.
INDEXED	The value of the *plan account* increases on each *plan anniversary*, in line with the *Retail Prices Index* (RPI) rounded to the next 0.25%. 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*. *Your plan account* cannot exceed £18,000,000, including any increases as a result of indexation. If *your* cover lasts for the whole of *your* life then the increases will be applied automatically until the *plan anniversary* immediately before *your* 80th birthday. If *your plan* is a *joint life plan* this will be based on the younger of the two *persons covered*. At this point *we* will write to *you* and ask *you* to confirm whether *you* want *your plan account* to continue to be indexed. If *you* do not tell *us* that *you* want *your plan account* to be indexed *we* will automatically change it to a level *plan account*.
DECREASING	The value of the *plan account* decreases over the life of the *plan*. It decreases in the same way that the outstanding capital on a repayment mortgage would if the mortgage had: • A 7% annual equivalent interest rate • The same term as the *plan* *You* can only have a *decreasing account* if *your plan* has a *fixed term*.

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 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.

Cover under *your* Later Life Option, including Funeral Cover, will begin once other specific covers terminate. There is more about this in provision C1.

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
SINGLE LIFE PLAN	*We* will pay the *benefit* if the *person covered* dies, or is diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit*, the *plan* ends.
JOINT LIFE FIRST DEATH	With a *joint life first death plan*, there are two people covered. If both people have Life Cover, *we* will pay the *benefit* if one of those people dies, or is diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit* 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 *plan*, the *plan* continues. The remaining person can apply to *us* for new Life Cover under a new *plan*. For more about this, see provision D6.
JOINT LIFE SECOND DEATH	This option is only available if *you* have chosen *Whole of Life* Cover, see provision A3. With a *joint life second death plan*, there are two people covered. *We* will pay the Life Cover *benefit* after both of the people covered have died, or have been diagnosed with a *terminal illness* that meets *our* definition. When *we* have paid this *benefit* the *plan* will come to an end.

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*.

The maximum amount of Life Cover *we* will pay for each *person covered* under all policies issued by *us* is £18,000,000.

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 the death or diagnosis of *terminal illness* happens after the Life Cover's *date of expiry*. *Your plan schedule* shows this date.

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.

B1.4 LifestyleCare Cover

LifestyleCare Cover allows *you* to access some or all of *your* Life Cover 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 and Appendix 4.

LifestyleCare Cover is only available if *you* have chosen *Whole of Life* Cover. It is available on *single life plans* only.

B1.4.1 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. *Your* condition must meet one of the definitions set out in Appendix 4. *We* will use the criteria in Appendix 4 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.

We may ask *your* General Practitioner, and any *appropriate medical 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 4. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid.

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

B1.4.2 How much we will pay

Your plan schedule shows *your* amount of LifestyleCare Cover. If *your plan account* structure is indexed, *your* LifestyleCare Cover will increase in the same way as the *plan account* at each *plan anniversary*. For more about indexation see provision A1.

The amount *we* will pay depends on:

- How severe *your* condition is, and
- The amount of LifestyleCare Cover *you* have

The lump sum *we* will pay *you* will be a percentage of *your* amount of LifestyleCare Cover. The percentage depends on how severe *your* condition is.

There are two severity levels:

SEVERITY LEVEL	WHAT PERCENTAGE OF *YOUR* AMOUNT OF LIFESTYLECARE COVER *WE* WILL PAY
LEVEL 1	20%
LEVEL 2	100%

Appendix 4 shows which conditions are covered under Severity Level 1 and Severity Level 2.

B1.4.3 When we will not pay

We will not pay the *benefit* for LifestyleCare Cover if:

- *You* suffer from a condition that *we* do not cover
- *You* suffer from a condition that *we* excluded from *your* cover after assessing *your* application
- *Your* condition does not meet *our* definition for that condition
- *You* are making a subsequent claim that does not meet the criteria for a further payment
- *We* do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim
- *We* do not receive the medical evidence *we* need from *your* General Practitioner and any *appropriate medical specialists* who are treating *you*
- *We* believe the condition that led to *your* claim was one *you* were already experiencing before *your plan* started and which *you* should have disclosed to *us* when *you* first applied
- *You* have selected LifestyleCare Cover Protector, and *you* do not survive for at least 14 days after the date that *you* meet a severity level 2 definition.

B1.4.4 What happens if you need to make a subsequent claim

We will only make one Severity Level 1 payment for LifestyleCare Cover.

If *we* have paid *you* a claim under Severity Level 1 *you* can make a subsequent claim for a Severity Level 2 condition. This can be for the same condition, or a different one.

For the subsequent Severity Level 2 condition, *we* will pay the remaining amount of *your* LifestyleCare Cover.

B1.4.5 How your cover continues after a claim for LifestyleCare Cover

The way *your* cover continues after a claim will depend on whether *you* have chosen LifestyleCare Cover Protector.

There are two types of LifestyleCare Cover Protector - LifestyleCare Cover Protector (level 1) and LifestyleCare Cover Protector (level 1 & 2). *Your plan schedule* will indicate whether *you* have selected LifestyleCare Cover Protector and if so which type.

LifestyleCare Cover Protector not selected

If *we* make a payment to *you* for a Severity Level 1 condition, the amount of *your* Life Cover and LifestyleCare Cover will reduce by the amount *we* have paid *you*.

If *we* pay *you* a claim for a Severity Level 2 condition, LifestyleCare Cover will be removed from *your plan*. The amount of *your* Life Cover will reduce by the amount *we* have paid *you*. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

LifestyleCare Cover Protector (level 1)

If *you* have chosen LifestyleCare Cover Protector (level 1) and *we* make a payment for a Severity Level 1 condition, the payment will not affect the amount that is available for future Life Cover or LifestyleCare Cover claims.

If *we* pay *you* a claim under Severity Level 2, LifestyleCare Cover will be removed from *your plan*. The amount of *your* Life Cover will reduce by the amount *we* have paid *you*. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

LifestyleCare Cover Protector (level 1 & 2)

If *you* have chosen LifestyleCare Cover Protector (level 1 & 2) and *we* make a payment for a Severity Level 1 condition, the payment will not affect the amount that is available for future Life Cover or LifestyleCare Cover claims.

If *you* meet the definition for a Severity Level 2 condition and *you* survive for at least 14 days after *you* meet the definition *we* will pay *your* remaining LifestyleCare Cover amount. LifestyleCare Cover will be removed from *your plan*. The amount of *your* Life Cover will not reduce. If LifestyleCare Cover is removed from *your plan you* will no longer pay a premium for LifestyleCare Cover.

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 5% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from levels A to G. For more about severity levels, see 'How much *we* will pay', at provision B2.3. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster the lump sum *we* pay *you* may be increased. For more about Serious Illness Cover Booster please see provision B2.3.

Serious Illness Cover must be for a *fixed term*. If *your plan* also has Life Cover for 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 *functional activity tests* to assess *your* claim. For more about *functional activity tests* 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 *your* cover after assessing *your* application.	*Your plan schedule*
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 *life-changing event* which caused *you* to claim.	Provision B2.1
You are making a *permanent* disability claim, and *you* do not survive until the date when *we* confirm that *you* are totally and *permanently* 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 *you* want to claim within six months of the *life-changing event* 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 B2.1
We are not satisfied that the *serious illness* that has led to *your* claim occurred either while *we* were providing *you* with Serious Illness Cover, or was disclosed to *us* when *you* applied.	
Your Serious Illness Cover expires before the *life-changing event* which leads to *your* claim.	*Your plan schedule*

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
- The amount of cover *you* have
- Whether *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster

How severe your condition is

The lump sum *we* pay *you* will be a percentage of *your* Serious Illness Cover between 5% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from A to G. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster the lump sum *we* pay *you* may be increased. For more about Serious Illness Cover Booster please see below:

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	10%
G (least severe)	5%

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 to E. With Comprehensive cover you are covered for all the severity levels - from A to G.

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.

Serious Illness Cover Booster

If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster the lump sum that *we* pay *you* in the event of a claim for certain *serious illness* conditions may be increased.

The increase in the lump sum *we* pay *you* will depend on the *serious illness* condition.

For the conditions listed in Appendix 2.1 *we* will increase the lump sum *we* pay *you* to 100% of *your* Serious Illness Cover.

For the conditions listed in Appendix 2.2 the increase in the lump sum *we* pay *you* will depend on:

- *Your* age at the time *you* claim; and
- The number of dependent *children* covered under Optional Serious Illness Cover for *Children* or Education Cover in this *plan*.

The table below shows the percentage of *your* cover that *we* will pay for conditions listed in Appendix 2.2 depending on *your* age at the time *you* claim.

AGE ATTAINED AT DATE OF DIAGNOSIS	WHAT PERCENTAGE OF YOUR SERIOUS ILLNESS COVER WE WILL PAY	AGE ATTAINED AT DATE OF DIAGNOSIS	WHAT PERCENTAGE OF YOUR SERIOUS ILLNESS COVER WE WILL PAY
16 - 24	200	45	147.5
25	197.5	46	145
26	195	47	142.5
27	192.5	48	140
28	190	49	137.5
29	187.5	50	135
30	185	51	132.5
31	182.5	52	130
32	180	53	127.5
33	177.5	54	125
34	175	55	122.5
35	172.5	56	120
36	170	57	117.5
37	167.5	58	115
38	165	59	112.5
39	162.5	60	110
40	160	61	107.5
41	157.5	62	105
42	155	63	102.5
43	152.5	64 and older	100
44	150	-	-

If *we* accept a claim for a condition that is listed in Appendix 2.2 then, for each *child* that is covered under Optional Serious Illness Cover for *Children* or Education Cover at the time *you* make *your* claim *we* will pay *you* an additional amount. The additional amount that *we* will pay is 10% of *your* Serious Illness Cover up to a maximum of £25,000 per *child*.

Serious Illness Cover Booster does not apply to claims for Family Income Cover, Education Cover or Optional Serious Illness Cover for *Children*.

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. Any *serious illness*, that resulted from a single *life-changing event*, that progresses will be treated as a *progressive claim*.

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 Protected Cover option. For more about the Protected Cover option, see provision C9.

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 6 and Appendix 7.

When *we* make payments under Serious Illness Cover, the value of *your plan account* reduces by the amount *we* have paid *you*. Only one *benefit* will be paid under a condition where *you* have been included on an official *UK* waiting list for a procedure and have undergone surgery for the same procedure. The maximum amount available for future claims will be the remaining value of the *plan account*. If the amount *we* have paid *you* is equal to or greater than the value of *your plan account, your* Serious Illness Cover will come to an end. This works differently if *you* have the Protected Life and Serious Illness Cover option. For more about this, see provision C9.

Subsequent claims

If *you* have already claimed *we* will classify any subsequent claims *you* make 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* that was caused by the same *life-changing event*
When *we* won't pay	No further payment will be made if: • the severity of the *progressive claim* is the same as or lower than the severity level of the previous claim; or • if the previous claim was for a condition listed in Appendix 2.1. and the *progressive claim* is also for a condition that is listed in Appendix 2.1 or is for a severity level A condition.
When *we* will pay	If the severity level of *your progressive claim* is higher than the severity level of *your* previous 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 previous claim to the new claim. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your progressive claim* is for a condition listed in Appendix 2.2 *we* will calculate the amount *we* will pay as follows: • *We* calculate the amount *we* pay for a condition listed in Appendix 2.2. When *we* do this *we* will use *your* age at the date *you* meet the definition for the condition for which *you* are making *your progressive claim*; and • *We* will subtract from this the amount *we* have already paid *you* for the previous claim. *We* will base the amount *we* pay on the value of *your plan account* prior to the previous claims. *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 *unrelated 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 another *serious illness* that was caused by a different *life-changing event*
How *we* calculate the amount *we* will pay	*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 on the severity level of the subsequent claim.

There are four types of claim that *we* treat differently compared to the table above.

1. Subsequent claims due to Heart Attack or Stroke

If *you* make a valid claim that is caused by a Heart Attack or Stroke, *we* will treat any subsequent claim of the same or lower severity as an *unrelated claim* if:

- the subsequent claim is caused by the same *life changing event* as the previous claim; and
- the Heart Attack or Stroke that causes the subsequent claim occurs at least 30 days after the *life changing event* that caused the previous valid claim.

Note: Heart Attack and Stroke are treated as two different *life changing events*.

2. 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 claim*s, 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 'subsequent claims' – see above.

3. Subsequent permanent disability claims

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 previous claim to the new one. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your* claim is for a condition listed in Appendix 2 the amount *we* will pay will include any increase as a result of Serious Illness Cover Booster; 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 previous claim to the new one, as above. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your* new claim is for a condition listed in Appendix 2 the amount *we* will pay will include any increase as a result of Serious Illness Cover Booster; 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, or
- Under a different *body system category*.

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*
- *We* will only pay a subsequent Serious Illness Cover claim if it is for a condition or illness that is not related to the underlying cause of *your permanent* disability claim

4. Subsequent claims under the cancer body system category if you have the Cancer Relapse Benefit

This is only applicable to claims under Comprehensive Serious Illness Cover. For more information see provision B2.8 Cancer Relapse *Benefit*.

B2.8 Cancer Relapse Benefit

Cancer Relapse *Benefit* pays a lump sum *benefit* if *you* are diagnosed with a relapse of cancer and make a subsequent claim under the cancer *body system category*. Cancer Relapse *Benefit* is automatically included on Comprehensive Serious Illness Cover.

We will pay a claim under Cancer Relapse *Benefit* if the condition occurs after a remission* period of at least one year following the *life changing event* that caused *your* previous claim.

We will pay out Cancer Relapse *Benefit* in two ways:

1. *We* will pay a subsequent claim for the same cancer that recurs at the same or lower severity
2. *We* will increase the lump sum *we* pay *you* by 50%.

*Remission is defined as being cancer free after the completion of chemotherapy, radiotherapy, surgical treatment or biological therapy (if indicated), and confirmed by the subsequent absence of radiological or biochemical (including molecular) evidence of disease. Hormone treatment is not regarded as active treatment for purposes of the remission definition.

B2.8.1 When we will pay the benefit

1. Subsequent claims under Cancer Relapse Benefit

Under Cancer Relapse *Benefit we* will pay subsequent claims for the relapse of cancer caused by the same *life changing event* at the same or lower severity level compared to the previous claim. All subsequent claims made under Cancer Relapse *Benefit* will be calculated using the *Plan Account* immediately prior to the claim being made.

Please see provision B2.7 for details on how *we* pay progressive and unrelated subsequent claims.

2. Lump sum increase for subsequent claims

Cancer Relapse *Benefit* increases the lump sum that *we* pay *you* by 50%, in the event of a subsequent claim under the cancer *body system category*.

Definition of Cancer - For Cancer Relapse Benefit

Cancer Relapse *Benefit* is only payable if the subsequent claim is for one of the following conditions under the cancer *body system category*.

- Severity level A condition;
- Severity level C condition;
- Cancer – excluding less advanced cases

Additionally *we* will only pay Cancer Relapse *Benefit* if *we* have previously paid *you* a claim for one of the above conditions.

See Appendix 1 for a full list of conditions *we* cover under the cancer *body system category*.

B2.8.2 When we will not pay the benefit

We will not pay under Cancer Relapse *Benefit* if the relapse of cancer occurs within a one year remission* period following the previous *life changing event* that lead to a valid claim under the cancer *body system category*.

We will pay *you* a maximum of twice under the Cancer Relapse *Benefit* over the length of *your plan*.

B2.8.3 How Cancer Relapse Benefit affects the plan account

When *we* make a payment under Cancer Relapse *Benefit*, the value of *your plan account* will only reduce by the amount *we* would have paid *you* before *we* increased the payment by 50%.

B2.9 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 (including Serious Illness Cover Booster) 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 Protected Life and Serious Illness Cover option – for more about this option, see provision C9.
- 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 calculate the amount available for future *serious illness* claims by subtracting the total amount paid for claims under Serious Illness Cover (including Serious Illness Cover Booster) from *your plan account*. The amount of *your* Serious Illness Cover will be *your* chosen percentage of the *plan account*. *Your* Life Cover amount will not change and may exceed the amount of the *plan account*. 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 C3.

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 Protected Life and Serious Illness Cover option or Protected Life Cover. For more about these, see 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; and
- 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 (including any payments from Cancer Relapse *Benefit*). This is the lower of:

- £3,000,000; (£4,000,000 if Serious Illness Cover Booster is selected) and
- 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; and
  - 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. *Your* Later Life Option, including Funeral Cover, will also be removed from *your plan*.

If *you* are also covered by other policies by *us*, the overall maximum amount that *we* will ever pay in respect of a *person covered* for Disability Cover for Business, Serious Illness Cover for Business, Serious Illness Cover Protector, Serious Illness Cover, Cancer Relapse *Benefit*, Disability Cover, Family Income Cover payable on diagnosis of a *serious illness* and Education Cover payable on diagnosis of a severity A *serious illness* is £3,000,000. This overall maximum amount is increased to £4,000,000 if *your plan schedule* indicates that *you* have included Serious Illness Cover Booster.

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.

B2.10 Family Benefit

If *you* have Serious Illness Cover in *your plan*, *we* automatically include Family *Benefit*.

Family *Benefit* does not need *underwriting*. Family *Benefit* pays a lump sum of £5,000 in the circumstances described in this provision.

B2.10.1 When we will pay the benefit

We will pay Family *Benefit* if *your* claim meets one or more of the following criteria:

a. Complications of Pregnancy

We will pay Family *Benefit* of £5,000 if *you, your* spouse or *your* civil partner is diagnosed by a Consultant Obstetrician with one of the following conditions:

- Disseminated Intravascular Coagulation (DIC)*
- Eclampsia (this excludes Preeclampsia)*
- Ectopic Pregnancy*
- Foetal death in utero after at least 20 weeks gestation and confirmed by a death certificate
- Hydatidiform Mole*
- Placental Abruption*
- Still birth (excluding elective pregnancy termination) after at least 20 weeks gestation.

b. Specified Congenital Conditions

We will pay Family *Benefit* of £5,000 if any *child* who was born living and during the period of cover is diagnosed with any of the following conditions after the *start date* of the cover:

- Cerebral Palsy - a definite diagnosis of Cerebral Palsy by an *appropriate medical specialist*
- Cystic Fibrosis – a definite diagnosis of Cystic Fibrosis by an *appropriate medical specialist*
- Downs Syndrome – a definite diagnosis of Downs Syndrome by an *appropriate medical specialist*
- Edwards Syndrome – a definite diagnosis of Edwards Syndrome by an *appropriate medical specialist*
- Osteogenesis Imperfecta – a definite diagnosis of Osteogenesis Imperfecta by an *appropriate medical specialist*
- Patau Syndrome – a definite diagnosis of Patau Syndrome by an *appropriate medical specialist*
- Spina Bifida – a definite diagnosis of Spina Bifida by an *appropriate medical specialist*
- Surgical treatment of Craniosynostosis - surgical treatment of Craniosynostosis by a Consultant Neurosurgeon.

c. Children's Funeral Contribution

We will pay *Children's* Funeral Contribution of £5,000 towards the cost of the funeral if any *child* dies before the *date of expiry* of *your* Serious Illness Cover.

The maximum amount of *Children's* Funeral Contribution that *we* will pay following the death of a *child* across all *plans* which *you* hold with VitalityLife is £5,000.

We will only pay *Children's* Funeral Contribution in respect of a person who:

- Has not reached the first *plan anniversary* after their 18th birthday (23rd birthday if they are in full-time education), and
- Is *your* natural *child*, adopted *child* or step-child, and
- Is looked after by or is financially dependent on *you*
- Is a *Resident of the United Kingdom*.

Children's Funeral Contribution includes all *your children* for the term of the cover.

We will only pay the *benefit* if:

- *We* receive *your* written claim form within six months of the *life-changing event*
- *You* provide *us* with any evidence *we* ask for
- *Your child* was born living.

B2.10.2 When we will not pay Family Benefit

We will not pay the Family *Benefit* if:

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

A maximum of one payment will be made under each of the three categories (Complications of Pregnancy, Specified Congenital Conditions and *Child* Funeral Contribution) for each *child* across all VitalityLife *plans*.

For the Complications of Pregnancy conditions listed in section B2.10.1.a that have been marked with an asterix, *we* will only make one payment per pregnancy, rather than per *child*.

In addition, no claim can be made for any Complications of Pregnancy or Specified Congenital Conditions which existed (whether or not a diagnosis was made or any symptoms were evident) within the first 9 months of the *start date* of *your* Serious Illness Cover.

B2.10.3 How much we will pay

We will pay £5,000 for each claim for Family *Benefit*. The total amount that *we* will pay for all claims under this *benefit* on all *plans* which *you* hold with VitalityLife is £20,000.

Claims *we* pay for Family *Benefits* will not reduce *your plan account*.

B2.10.4 When your Family Benefit will end

Your Family *Benefit* will end on the earliest of:

- *your* Serious Illness Cover's *date of expiry*, or
- when *we* have paid a total of £20,000 under Family *Benefit*, or
- the *plan* ceasing.

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 three types of Income Protection Cover – Short Term 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 all 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 B3.6.

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

- Two months
- Three months
- Six months
- 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.

If *you* work as a teacher, for a council or for the NHS and *you* have selected a 12 months *deferred period*, *we* may start to pay *your* monthly *benefit* according to *your* employer's sick-pay structure. For more information please see provision B3.10.

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
7 days	Immediately
1 month	2 weeks
2 months	2 weeks
3 months	1 month
6 months	2 months
12 months	2 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.

If public sector *deferred period* applies to *you* then *you* need to give *us* written notice within 2 weeks.

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
- *Your pre-incapacity earnings* evidence

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.

B3.2 How much we will pay

Your plan schedule shows the monthly *benefit you* have chosen for *your* Income Protection Cover. If *you* need to claim, *we* will pay *you* the lesser of:

- *Your* monthly *benefit* amount, and
- The *maximum monthly benefit amount* less any continuing income

The maximum monthly *benefit* amount is calculated as follows:

- 60% of the first £5,000 per month of *your pre-incapacity earnings*, plus 50% of *your pre-incapacity earnings* in excess of £5,000 per month

If *your* Income Protection Cover includes indexation, *your* monthly *benefit* amount will increase annually in line with the *Retail Prices Index* rounded to the next 0.25%. Indexation increases will not apply while *we* are paying a claim under this cover.

However, *you* will be eligible for the Earnings Guarantee if *your* income has reduced since *your plan* was taken out and:

- Immediately before *you* claim *you* have been *employed* working at least 30 hours a week, or
- Immediately before *you* claim *you* have been *self-employed* working at least 20 hours a week

If *you* are eligible for the Earnings Guarantee, *your maximum monthly benefit amount* is calculated as, the greater of:

- 60% of the first £5,000 per month of *your pre-incapacity earnings*, plus 50% of *your pre-incapacity earnings* in excess of £5,000 per month, and
- Earnings Guarantee.

Your Earnings Guarantee is the lesser of £1,500 and *your* monthly *benefit* amount. If *your* Income Protection Cover includes indexation, *your* monthly *benefit* amount and Earnings Guarantee will both increase annually in line with the *Retail Prices Index*, rounded to the next 0.25%. Indexation increases will not increase *your* monthly *benefit* amount or Earnings Guarantee while *we* are paying a claim under this cover.

The *maximum monthly benefit amount* will be reduced by continuing income which is 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;
- 60% of any salary, wages, income, fees, dividends or commission which *you* continue to receive directly from *employment* or *your* business and
- 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*.

The maximum monthly benefit amount we will pay is capped at £10,000 a month for Short Term Income Protection Cover and Primary Cover, or £16,666 a month for Comprehensive Cover.

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 B3.6.

Pre-incapacity earnings evidence

The information *we* need in order to confirm *your pre-incapacity earnings* may vary depending on whether *you* are *employed* or *self-employed*.

IF YOU ARE	DETAILS OF PRE-INCAPACITY EARNINGS
Employed	*Your* average gross monthly earnings for PAYE purposes from *your* own *occupation* in the 12 months before the incapacity. This includes: - The last 12 months' payslips or the last P60 certificate. - 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. - 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.
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.

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* have been *unemployed* or on a *career break* for longer than one month when *you* claim, *we* will assess *you* as a *house person*.

Indexation of cover (except during a claim)

Your plan schedule shows whether *you* have chosen for *your benefit* amount and Earnings Guarantee to:

- Remain level throughout the term of the cover; or
- Increase annually in line with the *Retail Prices Index* rounded to the next 0.25%

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. The amount by which *your* premium will increase will depend on the percentage rise in the *Retail Prices Index* at the time *your* cover increases.

Your premiums will increase in one of three ways:

THE PERCENTAGE INCREASE IN THE *RETAIL* PRICES *INDEX*	PREMIUM INCREASE AMOUNT
Above 0% up to and including 1.75%	Total of the percentage increase in the *Retail Prices Index* plus 1.5%
2% up to and including 7.75%	Total of the percentage increase in the *Retail Prices Index* plus 2.5%
8% and above	Total of the percentage increase in the *Retail Prices Index*, to a maximum of 10%, plus 3.5%

If the percentage change in the *Retail Prices Index* is 0% or less, then there will be no change in *your* cover amount or premium.

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*
- When *we* are paying *you* a *benefit* under *your* income protection cover

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

Indexation increases will not increase *your benefit* amount while *we* are paying a claim under this cover – unless *your* cover includes the escalation of claims in payment option. For more about this, see 'Escalation of claims in payment' below.

Escalation of claims in payment

If *your* cover includes the escalation of claims in payment, *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 Short Term, Primary, or Comprehensive Income Protection Cover.

With Short Term and Primary Income Protection Cover, the increase in *your benefit* amount will be in line with the *Retail Prices Index* rounded to the next 0.25%. 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* rounded to the next 0.25%, subject to an annual minimum of 0% and maximum of 10%; or
- In line with the *Retail Prices Index* rounded to the next 0.25%, 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*
- 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.

Hospitalisation benefit

If *you* have Comprehensive Income Protection Cover, *your plan* will include a Hospitalisation *benefit*.

During *your deferred period*, if *you* are hospitalised for medically necessary treatment for seven consecutive nights or more, *we* will provide a *benefit* of £100 a day from the seventh day onwards for the period that *you* remain in hospital.

We will pay the Hospitalisation *benefit* at the end of each month following hospitalisation. *You* will need to provide *us* with satisfactory proof of *your* entitlement to the *benefit* within 30 days of *us* asking for it.

We will limit the number of days *we* pay to an overall maximum of 90 nights. If *you* are also covered by other policies issued by *us*, the overall maximum amount that *we* will ever pay in respect of a *person covered* for Hospitalisation *benefit* is £9,000. *On joint life plans*, this maximum applies to each *person covered* separately.

We will stop paying *you* the Hospitalisation *benefit* on the earliest of:

- *You* leaving hospital
- The end of *your deferred period*
- The end of *your* Income Protection Cover's *date of expiry*
- The *plan* ceasing
- *You* being removed from the *plan*
- *Your* death

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*
- 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 Short Term, Primary or Comprehensive Income Protection Cover. The amount is fixed when *you* set up *your plan*.

For Short Term and Primary Income Protection 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
2. Multiplying this number by 12
3. Dividing it by 365
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 *benefit*, or by asking *you* to return the excess amount to *us*.

B3.3 When we may not pay or reduce the amount we pay you

If *you* provided *us* with inaccurate information at application, this may impact the amount *we* pay *you*.

B3.4 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

If *you* have selected *Primary* or *Comprehensive Income Protection Cover*, *we* will stop paying *you benefits* on the cover's *date of expiry*. *Your plan schedule* shows this date.

If *you* have selected Short Term Income Protection Cover, *we* will stop paying *you benefits* under Income Protection Cover on the earlier of:

- The cover's *date of expiry*; and
- The *benefit* payment term

Benefit payment term under Short Term Income Protection Cover

Short Term Income Protection Cover pays *you* a total of 24 monthly *benefit* payments for each claim. Once *you* have received 24 monthly *benefit* payments, *your* payments will stop, even if *you* are still unable to work.

If *you* have already claimed under Short Term Income Protection, any subsequent claim will be assessed and paid out under the following circumstances:

1. **The reason you are unable to work is linked to the same condition as your previous claim and the subsequent claim is made within 6 months of the previous claim.**
   We will *pay out* for this subsequent claim and waive the *deferred period*. The total combined number of *benefit* payments for the subsequent and original claim, are limited to 24 monthly *benefit* payments.
2. **The reason you are unable to work is linked to the same condition as your previous claim, the subsequent claim is made after 6 months of the previous claim and you have not returned to work for at least 6 months.**
   We will *pay out* this subsequent claim following the end of *your deferred period*. The total combined number of *benefit* payments for the subsequent and original claim, are limited to 24 monthly *benefit* payments.
3. **The reason you are unable to work is linked to the same condition as your previous claim and the subsequent claim is made following 6 months of you going back at work since the previous claim.**
   We will *pay out* this subsequent claim subject to *you* having returned to work continuously for at least 6 months, working the same amount of hours as *you* did prior to the claim being made. This means when *your* claim is accepted, *we* will start paying *your benefit* again after the end of *your deferred period*. *We* will *pay you* another total of 24 monthly *benefit* payments.
4. **The reason you are unable to work is not linked to the same condition as your previous claim.**
   We will *pay out* this subsequent claim following the end of *your deferred period*. The total number of *benefit payments* for *your* new claim are limited to 24 monthly *benefit* payments.

For Short Term, Primary and Comprehensive Income Protection Cover, *we* will stop paying *you benefits* earlier 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
- *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 *plan* 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.

B3.5 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 183 days *benefit* in any 365 day period. *We* will also limit the amount *we* pay to an overall maximum of 365 day *benefit*.

B3.6 What happens if you are not in employment when you make a claim or you have chosen House person 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.

House person claims

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

- A *house person*
- A student
- Retired
- Working less than 16 hours a week
- *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 per month. 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 per month. For more about indexation, see provision B3.2.

We will pay an extra £100 per month for any *children* that are dependent on *you*. This amount is per *child*, but is subject to a monthly maximum of £300 per month 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*
- *You* no longer fail three out of the six *activities of daily living*
- *You* have selected Short Term Income Protection Cover and *your benefit* has ended according to provision B3.4
- *Your* cover reaches its *date of expiry*

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*.

B3.7 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 and *you* have been unable to work for at least three consecutive months, *we* will pay *you* a back to work *benefit*. *We* will only pay this *benefit* once *we* have stopped paying *you* a *benefit* 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 Short Term, Primary, or Comprehensive Income Protection Cover.

- Short Term and 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 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 pre-incapacity earnings* (depending on which amount *we* have used to assess *your* claim)
2. *We* divide the result by *your pre-incapacity earnings*
3. *We* then multiply that result by *your* monthly Income Protection *benefit*

How long we will pay for

We will stop paying *you benefits* under rehabilitation or proportionate *benefit* if:

- *You* have selected Short Term Income Protection Cover and *your benefit* has ended according to provision B3.4
- *Your* cover reaches its *date of expiry*

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*.

B3.8 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.

B3.9 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 B3.6 and B3.7.

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*

- *You* Income Protection Cover reaches its *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover
- *You* have selected Short-Term Income Protection Cover and *your benefit* has ended according to provision B3.4
- *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 C6. Waiver of Premium on Incapacity means that *we* will waive the *plan* premium 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 C6.1.

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 Short Term or 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 VitalityHealth *plan* 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 *plan* or scheme. *We* will waive them from the date *you* became incapacitated, for a maximum of six months.

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

B3.10 Public Sector Deferred Period

If *you* work as a teacher, for a council or for the NHS and *you* have selected a 12 months *deferred period*, *we* may start to pay *your* monthly *benefit* that links to *your* employer's sick-pay structure. If *you* have not chosen the 12 months *deferred period*, the public sector *deferred period* will not apply to *you*. The following *deferred periods* will apply to *your plan* depending on *your occupation*. The *deferred period* varies by the length of *your* service with *your* employer:

NHS AND COUNCIL EMPLOYEES		
LENGTH OF SERVICE	50% OF MONTHLY *BENEFIT* AMOUNT	100% OF MONTHLY *BENEFIT* AMOUNT
	Deferred Period	
Up to 1 year	1 month	3 months
Between 1 and 2 years	2 months	4 months
Between 2 and 3 years	4 months	8 months
Between 3 and 5 years	5 months	10 months
Over 5 years	6 months	12 months
If *your plan* has been in force for more than 5 years	6 months	12 months

TEACHERS (ENGLAND, WALES AND NORTHERN IRELAND)		
LENGTH OF SERVICE	50% OF MONTHLY *BENEFIT* AMOUNT	100% OF MONTHLY *BENEFIT* AMOUNT
	*Deferred Period**	
Up to 4 months	-	25 days
Between 4 months and 1 year	50 days	75 days
Between 1 and 2 years	50 days	100 days
Between 2 and 3 years	75 days	150 days
Over 3 years	100 days	200 days
If *your plan* has been in force for more than 3 years	100 days	200 days

*Based on working days

TEACHERS (SCOTLAND)		
LENGTH OF SERVICE	50% OF MONTHLY *BENEFIT* AMOUNT	100% OF MONTHLY *BENEFIT* AMOUNT
	Deferred Period	
Up to 4 months	-	1 month
Between 4 months and 1 year	1 month	2 months
Between 1 and 2 years	2 months	4 months
Between 2 and 3 years	4 months	8 months
Between 3 and 5 years	5 months	10 months
Over 5 years	6 months	12 months
If *your plan* has been in force for more than 5 years	6 months	12 months

Who is eligible for the public sector deferred period

To be eligible for the public sector *deferred period you* must have selected either Primary or Comprehensive Income Protection Cover and be *employed* in one of the *occupations* mentioned below throughout *your plan* and immediately before *you* claimed. *Your* sick-pay structure immediately before *you* claimed must be based on one of the specified structures below.

Teachers (England and Wales)

Teachers (Including head teachers) who work in schools or in centrally managed LEA services and who are remunerated either on full-time basis or a part-time basis and their sick-pay is set out in the 'Conditions of Service for School Teachers in England and Wales', also known as the Burgundy Book.

Teachers (Scotland)

Teachers who work in Scotland and are governed by the Scotland Negotiating Committee for Teachers (SNCT) bargaining arrangements and their sick-pay is set out in SNCT Handbook of Conditions of Service.

Teachers (Northern Ireland)

Teachers who work in Northern Ireland and their sick-pay is in accordance with the Department of Education, Teachers Terms and Conditions.

NHS employees

Employees who work for NHS or one of NHS employers and their sick-pay is based on part 3 section 14 of the NHS Terms and Conditions of Service Handbook, or the equivalent at the time of claim.

Council employees

Employees of local authorities or other authorities of equivalent status in the *UK* and their sick-pay is set out based on National Joint Council for Local Governments Services' "National Agreement on Pay And Conditions of Service" booklet, also known as Green Book.

Linked Deferred Period

To align *your deferred period* to *your* sick-pay structure, *you* do not need to be continuously off-work. *We* will take into account the total time *you* have been off work in any year for the same condition to work out when *we* will start paying *your* claim. A year refers to a calendar year except for teachers (England, Wales and Northern Ireland) where a year is regarded as beginning on 1st April and ending on 31st March the following year.

B3.11 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. LATER LIFE OPTIONS

Dementia and FrailCare Cover and Dementia and FrailCare Cover Plus are two Later Life Options available to select at the start of *your* Serious Illness Cover.

Your plan schedule shows if *you* have included Dementia and FrailCare Cover or Dementia and FrailCare Cover Plus on *your plan* and, where *you* have joint life cover, the persons for which the cover is available on. Cover under *your* Later Life Option will automatically begin after *your* Serious Illness Cover's *date of expiry*. When *you* are covered under *your* Later Life Option, *we* will pay a lump sum if *you* are diagnosed with an illness or condition that *we* cover and which meets *our* definition of that condition. *We* set these conditions out in Appendix 5.

You are able to cancel *your* Later Life Option at any time if *you* do not wish to be covered under *your* option after the expiry of *your* Serious Illness Cover.

If *you* also have Term Life Cover, *your* Later Life Option will also include Funeral Cover. Funeral Cover automatically begins after *your* Life Cover's *date of expiry*, and pays a lump sum if *you* die.

C1.1 How much we will pay

If *you* are diagnosed with an illness or condition that *we* cover, the amount *we* will pay depends on:

- How severe *your* condition is, and
- *Your* Later Life Option amount.

How severe your condition is

The lump sum *we* will pay *you* will be a percentage of *your* Later Life Option amount between 25% and 100%. The percentage depends on how severe *your* condition is, based on a scale from A to D.

SEVERITY LEVEL	THE PERCENTAGE OF *YOUR* COVER *WE* WILL PAY
A	100%
B	75%
C	50%
D	25%

Appendix 5.1 shows which severity levels apply to which conditions.

The amount of cover

Your Later Life Option amount is calculated when *your plan* starts and depends on *your* Serious Illness Cover amount, subject to a maximum amount. The Later Life Option amount when *your plan* starts is calculated as the lesser of:

- The amount of Serious Illness Cover at the start of *your plan* multiplied by 50% for Dementia and FrailCare Cover or 100% for Dementia and FrailCare Cover Plus, and
- The maximum amount of *your* Later Life Option available at the start of *your plan*.

Your plan schedule shows *your* Later Life Option amount, as well as the maximum amount available at the start of *your plan*.

Your Later Life Option amount will be adjusted for any claims *you* make under Serious Illness Cover and any changes *you* make to *your* Serious Illness Cover amount. For more about how a claim affects *your* Later Life Option, see provision C1.10. For more about how changes to *your* Serious Illness Cover affect *your* Later Life Option, see provision C1.13.

If *your* Serious Illness Cover is indexed, *your* Later Life Option amount will also increase at each *plan anniversary* and may increase above the maximum amount available at the start of *your plan*. For more about indexation, see provision A1.

C1.2 When we will pay the benefit

Cover under *your* Later Life Option will automatically begin after *your* Serious Illness Cover's *date of expiry*.

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

- *You* must be diagnosed with a condition that *we* cover. *Your* condition must meet one of the definitions set out in Appendix 5.1. *We* will use the criteria in Appendix 5.1 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.

We will ask *your* General Practitioner, and any *appropriate medical specialists* who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness or conditions. For more about this, see Appendix 5.1. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid.

Benefits under *your* Later Life Option will be due when *we* confirm that the claim is valid – irrespective of when the claim is made.

If *you* are covered by more than one policy issued by *us*, *benefits* under Later Life Options will only be paid on one policy.

C1.3 When we will not pay

We will not pay under *your* Later Life Option if:

- Cover under *your* Later Life Option has not begun.
- *You* suffer from a condition *we* do not cover.
- *Your* condition does not meet *our* definition for that condition.
- The claim is due to a condition what *we* have excluded from *your* Serious Illness Cover.
- *We* do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim.
- *We* do not receive the medical evidence *we* need from *your* General Practitioner and any *appropriate medical specialists* who are treating *you*.
- *You* do not survive for at least 14 days after the date of the *life-changing event* which caused *you* to claim.
- *You* have already claimed for a condition under *your* Serious Illness Cover which is regarded as a related condition under *your* Later Life Option. All related conditions are listed in Appendix 5.2.

C1.4 What happens if your claim meets multiple definitions at one time

If *your* claim meets multiple definitions at one time, *we* will only pay out for one definition. *We* will pay out based on the definition with the highest severity at that time.

C1.5 What happens if you need to make a subsequent claim

If *you* have already claimed under *your* Later Life Option, any subsequent claims will be paid as below.

SUBSEQUENT CLAIMS UNDER LATER LIFE OPTIONS	
When *we* won't pay	No further payment will be made if the severity level of *your* subsequent claim is the same as or lower than the severity level of *your* previous claim
When *we* will pay	If the severity level of *your* subsequent claim is higher than the severity level of *your* previous, most recent, claim.
How *we* calculate the amount we pay	*We* will base the amount *we* pay on the increase in severity from the previous claim to the new claim. The pay-out will be based on *your* Later Life Option amount.

C1.6 What happens if you claim for a condition during your Serious Illness Cover term

Any claims made under Serious Illness Cover will reduce *your* Later Life Option amount in proportion to the reduction in *your* Serious Illness Cover amount. This works differently if *you* have a Protected Cover option. For more about the Protected Cover options, see provision C12.

C1.7 Your Later Life Option premium

If *you* select Dementia and FrailCare Cover, no additional premium is payable for this option during *your* Serious Illness Cover term. If *you* select Dementia and FrailCare Cover Plus, an additional premium will be payable for this option from the start of *your* Serious Illness Cover. The additional premium will continue to be payable when cover under Dementia and FrailCare Cover Plus begins. *Your plan schedule* shows *your* Dementia and FrailCare Cover Plus premium.

For all Later Life Options, *your* Serious Illness Cover premium will continue to be payable when cover under *your* Later Life Option begins. *Your* Serious Illness Cover premium will be subject to the following adjustments after *your* Serious Illness Cover's *date of expiry*:

- Removal of the Protected Cover option premium
- Removal of the premium attributable to Serious Illness Cover Booster.
- Removal of the premium attributable to Comprehensive Serious Illness Cover when compared to Primary Serious Illness Cover.
- Reducing *your* premium in proportion to any limitation on *your* Later Life Option amount resulting from the maximum amount.

If *your plan account* includes indexation, *your* Later Life Option will also be indexed. This means both *your* cover amount and premium will continue to increase with indexation. The amount by which *your* premium will increase will depend on *your* age and the percentage rise in the *Retail Prices Index* at the time *your* cover increases. For more about how indexation could affect *your* premiums, see provision D1.3. *You* can remove indexation from *your plan* at any time.

Your premiums will continue to change by either *your Vitality Status* or both *your Vitality Status* and *Wellness Status*. Additionally, premiums for Dementia and FrailCare Cover Plus will continue to change by either *your Vitality Status* or both *your Vitality Status* and *Wellness Status*, if *you* have it.

This works differently if *you* have made a successful claim under *your* Later Life Option. Please see provision C1.10 for more information on this.

C1.8 When your Later Life Option will end

Your Later Life Option will end when the first of the following occurs:

- *You* have claimed *your* full Later Life Option amount
- It is removed from *your plan*
- *You* cancel *your plan*
- *Your* death.

C1.9 Funeral Cover

Your Later Life Option includes Funeral Cover if *you* also have Term Life Cover. Funeral Cover pays a lump sum when *you* die after *your* Life Cover *date of expiry*.

C1.9.1 How much we will pay

Your Funeral Cover amount is calculated when *your plan* starts and depends on *your* Life Cover amount, subject to a maximum amount.

Your Funeral Cover amount when *your plan* starts is calculated as the lesser of:

- The amount of Life Cover at the start of *your plan* multiplied by 10%, and
- The maximum amount of Funeral Cover available at the start of *your plan*.

Your plan schedule shows *your* Funeral Cover amount, as well as the maximum amount available at the start of *your plan*.

Your Funeral Cover amount will be adjusted for any changes to *your plan account*. This includes claims *you* make under Serious Illness Cover, or any changes *you* make to *your* Life Cover amount. For more about how claims affect *your plan account* or how changes to *your plan* affect *your* Funeral Cover, see provisions B2.9 and C1.13 respectively. Claims under Serious Illness Cover will reduce *your* Funeral Cover amount in proportion to the reduction in the *plan account*. This works differently if *you* have a Protected Cover option. For more about the Protected Cover options, see provision C11.2.

If *your* Life Cover is indexed, *your* Funeral Cover amount will also increase at each *plan anniversary* and may increase above the maximum amount available at the start of *your plan*. For more about indexation, see provision A1.

C1.9.2 Your Funeral Cover premium

No additional premium is payable for Funeral Cover during *your* Life Cover term. *Your* Life Cover premium will continue to be payable when cover under Funeral Cover begins. *Your* Life Cover premium will be subject to the following adjustments after its *date of expiry*:

- Reducing *your* premium in proportion to any limitation on *your* Funeral Cover amount resulting from the maximum amount.

If *your plan account* includes indexation, *your* Funeral Cover will also be indexed. This means both *your* cover amount and premium will continue to increase with indexation. The amount by which *your* premium will increase will depend on *your* age and the percentage rise in the *Retail Prices Index* at the time *your* Funeral Cover increases. For more about how indexation could affect *your* premiums, see provision D1.3. *You* can remove indexation from *your plan* at any time.

Your premium will continue to change by either *your Vitality Status* or both *your Vitality Status* and *Wellness Status*. This works differently if *you* have made a successful claim under *your* Later Life Option. Please see provision C1.10 for more information on this.

C1.9.3 When your Funeral Cover will end

Your Funeral Cover will end when the first of the following occurs:

- Once cover under *your* Later Life Option begins, it is removed from *your plan*
- *You* have claimed *your* full Serious Illness Cover amount
- The *benefit* is paid out upon death
- *You* cancel *your plan*

C1.10 What happens if you claim under your Later Life Option

Any pay out under *your* Later Life Option does not impact *your* Funeral Cover.

Premiums for *your* Later Life Option will continue to be payable until *you* have claimed *your* full Later Life Option amount. Similarly, premiums for Funeral Cover will continue to be payable until *you* have claimed *your* Funeral Cover amount.

If *you* make a successful claim under *your* Later Life Option, *we* will not increase *your plan premium* by either *your Vitality Status* or both *your Vitality Status* and *Wellness Status*. However, if *you* are eligible for a premium reduction, *we* will continue to apply this to *your plan premium*.

Once *you* have claimed *your* full Later Life Option amount, the cover will end. However, *your* Funeral Cover will continue and *your* Funeral Cover premium will continue to be payable.

If *your plan* includes indexation, this will be removed from *your* Later Life Option. However, *your* Funeral Cover will continue to be indexed following a Later Life Option claim.

C1.11 What happens if your Serious Illness Cover and Life Cover have different terms

If *your* Serious Illness Cover term ends before *your* Life Cover term, cover under *your* Later Life Option will begin as described in C1.2. *Your* Life Cover will continue until it reaches its *date of expiry,* after which *you* will be covered under Funeral Cover. Premiums will be payable for *your* Later Life Option and Funeral Cover once *you* are covered under each individual cover. For more information about *your* Later Life Option and Funeral Cover premiums, see provision C1.7 and C1.9 respectively.

C1.12 How your Later Life Option works on joint life plans

For *joint life plans*, *your plan schedule* shows if *you* have included a Later Life Option on *your plan* and for which life the cover is available on. If a Later Life Option is included, the same option will apply to both *persons covered*.

For *joint life plans,* cover under the Later Life Option will automatically begin for each *person covered* on the *date of expiry* of their Serious Illness Cover. Each *person covered* will have their own separate *plan* with their Later Life Option. Each *person covered* is able to cancel their respective covers at any time if they do not wish to be covered under the Later Life Option after the expiry of their Serious Illness Cover.

Funeral Cover will only be included for each *person covered* that has both Term Life Cover and Serious Illness Cover. Cover under Funeral Cover will automatically begin on the *date of expiry* of their Life Cover. *Your plan schedule* shows which life Funeral Cover is available on.

Premiums will continue to be payable for the Later Life Option for each *person covered* after the expiry of their Serious Illness Cover. Similarly, premiums will continue to be payable for Funeral Cover for each *person covered* after the expiry of their Life Cover.

C1.13 How changes made to your plan during the term can impact your Later Life Option and Funeral Cover

If *you* make any changes during the term of *your plan* to either increase or decrease *your* Serious Illness Cover, *your* Later Life Option amount will be increased or decreased proportionately. The adjustment will take into account the maximum amount of *your* Later Life Option available at the time *you* ask *us* to change *your* cover.

Similarly, if *you* have Life Cover on *your plan*, and *you* make any changes during the term of *your plan* to either increase or decrease *your* Life Cover, *your* Funeral Cover amount will be increased or decreased proportionately. The adjustment will take into account the maximum amount of *your* Funeral Cover available at the time *you* ask *us* to change *your* cover.

You will not be able to increase *your* Later Life Option or Funeral Cover amount if *your* remaining Serious Illness Cover term is below the minimum required *plan* term for Later Life Options.

If *you* make any of the following changes during the term of *your plan*, *you* will not be eligible for later Life Options or Funeral Cover:

- Reduce *your* Serious Illness Cover term below the minimum required *plan* term
- Remove Serious Illness Cover
- Remove Vitality Optimiser
- Remove Wellness Optimiser

Once cover under *your* Later Life Option begins, it cannot be added to *your plan* again if:

- The option is removed
- *Your plan* is cancelled

Similarly, *you* will not be able to add it to any other *plan you* are covered under.

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

C2. 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*. Serious Illness Cover Booster does not apply to 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. *Children* can be covered from 30 days after their birth, unless *we* say otherwise for a specific condition.
We pay any *benefit*s under this cover to the *planholder*.

You don't have to have Serious Illness Cover to 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:

- *Your child* is diagnosed with a *serious illness* as defined in Appendix 1
- 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

SEVERITY LEVEL	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	10%
G (least severe)	5%

If *your* claim is for a *serious illness we* will usually assess using *functional activity tests,* or that is defined as total *permanent* disability (unable to do *your own occupation* ever again) *we* will assess *your child's* condition based on total *permanent* disability for *children* in Appendix 1.

See Appendix 1 for a list of conditions which require the use of *functional activity tests* to assess claims.

C2.2 How much we will pay

How much *we* will pay depends on:

- how severe *your child's* condition is
- the type of cover *you* have; and
- the amount of cover for *your child*

How severe your child's condition 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 G:

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

The type of cover you have

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 G.

If *you* have Primary cover, *your* Optional Serious Illness Cover for *Children* only includes severity levels A to E.

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.

The amount of cover

Your plan schedule shows the amount of Optional Serious Illness Cover for each *child*.

The maximum total amount of benefit

The maximum total amount of *benefit* that *we* will pay for each named *child* under this cover over the term of the *plan* is £100,000.

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

C2.3 When we will not pay

We will not pay the *benefit* if:

- The *life-changing event* that causes *you* to claim happens after *your* Optional Serious Illness Cover for *Children's date of expiry*
- The claim is due to a *pre-existing medical condition*

C2.4 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.

C2.5 How your cover continues after a claim

When *we* make payments under this cover, the amount of cover available for future claims for that *child* will reduce by the amount *we* have paid *you*. If *you* claim once and then again *we* may make a further payment. The circumstances in which *we* may make a further payment are outlined in provision B2.7. How *we* calculate the amount *we* will pay is also outlined in provision B2.7, however the calculation will be based on *your* amount of Optional Serious Illness Cover for *Children* rather than the *plan account*. Serious Illness Cover Booster does not apply to Optional Serious Illness Cover for *Children*.

C2.6 Indexed Cover

Your plan schedule will show whether *your* Optional Serious Illness Cover for *Children* is on a level or an indexed basis.

LEVEL OR INDEXED?	WHAT THIS MEANS
LEVEL	The amount of Optional Serious Illness Cover for *Children* will stay the same over the life of the *plan*. It will only change if something happens such as *you* change the cover.
INDEXED	The amount of Optional Serious Illness Cover for *Children benefit* increases on each *plan anniversary*, in line with the *Retail Prices Index* (RPI rounded to the next 0.25%). 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*.

C2.7 Hospitalisation benefit

Your plan also includes a Hospitalisation *benefit* on *your* Optional Serious Illness Cover for *Children*.

If *your child* is hospitalised for medically necessary treatment for 14 consecutive night or more following 30 days after their birth, *we* will provide a *benefit* of £100 a day from the fourteenth day onwards for the period that *your child* remains in hospital.

We will pay the Hospitalisation *benefit* at the end of each month following hospitalisation. *You* will need to provide *us* with satisfactory proof of *your* entitlement to the *benefit* within 30 days of *us* asking for it.

We will limit the number of days *we* pay to an overall maximum of 30 nights. The overall maximum amount that *we* will pay for any one *child* is £3,000. If *your child* is covered by more than one of *our plans* with Optional Serious Illness Cover for *Children*, this maximum applies to the total of all payments under these *plans* and not to each *plan* separately. This includes where a *joint life plan* has been split.

We will not pay out the Hospitalisation *benefit* if it is a result of *you* making a successful claim under Optional Serious Illness Cover for *Children*.

We will stop paying *you* the Hospitalisation *benefit* on the earliest of:

- *Your child* leaving hospital
- *Your child* has reached the *first plan anniversary* after their 18th birthday (23rd birthday if they are in full time education)
- *Your child* being removed from the *plan*
- The *plan* ceasing
- *Your child's* death
- *You* making a successful claim under Optional Serious Illness Cover for *Children* that results *in your child's* hospitalisation.

C3. 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.

C3.1 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

C3.2 How much we will pay

How much *we* will pay depends on:

- How much Disability Cover *you* have
- 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 3, 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 3, 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
- 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*
- *You* are covered by a waiver of premium. There is more about premium waivers in provisions C6 to C8

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 meet *our* definition of total *permanent* disability - unable, before age 70, to do *your own occupation* ever again
- *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 (including any payments as a result of Serious Illness Cover Booster) *benefit we* will pay for a *person covered* over the life of the *plan* is £3,000,000.

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.

If *you* are also covered by other VitalityLife *plans*, the overall maximum amount that *we* will ever pay in respect of a *person covered* for Disability Cover for Business, Serious Illness Cover for Business, Serious Illness Cover Protector, Serious Illness Cover, Disability Cover, Family Income Cover payable on diagnosis of a *serious illness* and Education Cover payable on diagnosis of a severity A *serious illness* is £3,000,000. This overall maximum amount is increased to £4,000,000 if *your plan schedule* indicates that *you* have included Serious Illness Cover Booster.

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.

C3.3 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.

Only one *benefit* will be paid under a condition where *you* have been included

on an official *UK* waiting list for a procedure and have undergone surgery for the same procedure.

C3.4 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*.

C3.6 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 *benefit*s under Disability Cover, Serious Illness Cover, Family Income Cover or Education Cover, *we* will pay all *benefit*s. This is subject to a maximum amount. For more about the maximum, see provision C3.2.

C3.7 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 *benefit*s will also be separate.

C3.8 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 7 shows how *we* deal with further claims. If *you* have a *joint life plan*, this applies separately to each *person covered*.

C3.9 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 *permanent* disability - unable, before age 70, to do *your own occupation* ever again
- 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*.

C4. 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.

C4.1 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 C4.2.

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 C4.2.

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 G. For more about severity levels, see 'How long *we* will pay the *benefit* for', at provision C4.2.

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 *functional activity tests* to assess *your* claim. For more about *functional activity tests*, 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.

C4.2 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. *You* have an option to select a guaranteed payment term of either five or ten years.

If *you* have not selected a guaranteed payment term, a one year period will apply to Primary Family Income Cover and a two year period will apply to Comprehensive Family Income Cover.

Your plan schedule will show the guaranteed payment term which applies to *your plan*.

Death or 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
- 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 G.

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)	100% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
B	75% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
C	50% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
D	25% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
E	15% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
F	10% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term
G (least severe)	5% of the longer of: • From date of diagnosis until the *date of expiry* • Guaranteed payment term

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 to E. With Comprehensive Cover *you* are covered for all the severity levels - from A to G.

C4.3 When we will not pay

We will not pay the *benefit* if the death or diagnosis of *terminal illness* happens after the Family Income Cover *date of expiry*. *Your plan schedule* shows this date.

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 *serious illness*	Provision C4.1
You suffer from a condition that *we* do not cover	Appendix 1
You suffer from a condition that *we* excluded from *your* cover after assessing *your* application	*Your plan schedule*
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 *life-changing event* which caused *you* to claim	Provision C4.1
You are making a *permanent* disability claim, and *you* do not survive until the date when *we* confirm that *you* are totally and *permanently* disabled	Appendix 1
You are making a subsequent claim that does not meet the criteria for a further payment	Provision C4.7
We do not receive written notice that *you* want to claim within six months of the *life-changing event* 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 C4.1
We believe the *serious illness* that led to *your* claim was one *you* were already experiencing before *your plan* started and which *you* should have disclosed to *us* when *you* first applied	
Your Family Income Cover expires before the *life-changing event* which leads to *your* claim	*Your plan schedule*

C4.4 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 C4.5.

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.

C4.5 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 *plan*. It will only change if something happens such as *you* change the cover.
INDEXED	The amount of Family Income Cover *benefit* increases on each *plan anniversary*, in line with the *Retail Prices Index* (RPI) rounded to the next 0.25%. 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*. The RPI increase will continue during a claim.

C4.6 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.

C4.7 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 *we* will classify any subsequent claims *you* make 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* 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* previous 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* previous claim, *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: • The *benefit* payment term had the condition been diagnosed at the higher severity level when the previous claim was accepted • The length of time that *we* have already paid the claim for the original condition
UNRELATED CLAIMS	
Definition	An *unrelated 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 another *serious illness* that was caused by a different *life-changing event* or one that is under a different *body system category*
If a claim is made after the end of a previous *benefit* payment term	If the *benefit* payment term for the previous claim has ended and *we* are no longer paying the regular monthly *benefit* amount *we* will treat the *unrelated claim* as a new claim. *We* will calculate the *benefit* payment term based on the severity of the *serious illness* which has caused the *unrelated claim*.
If a subsequent claim is made while the *benefit* is being paid due to a previous claim	If the *benefit* payment term for the previous claim has not yet ended and *we* are still paying the regular monthly *benefit* amount *we* may extend the *benefit* payment term. *We* will calculate the *benefit* payment term based on the severity of the *serious illness* which has caused the *unrelated claim*. If this *benefit* payment term is longer than the period until which the *benefit* for the previous claim will be paid, the *benefit* will be paid until the end of the *benefit* payment term for the subsequent claim. If this *benefit* payment term is shorter than the period until which the *benefit* for the previous claim will be paid, the *benefit* will be paid until the end of the *benefit* payment term for the previous claim.

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

1. **Subsequent claims due to Heart Attack or Stroke**

If *you* make a valid claim that is caused by a Heart Attack or Stroke, *we* will treat any subsequent claim of the same or lower severity as an *unrelated claim* if:

- the subsequent claim is caused by the same *life changing event* as the previous claim; and
- the Heart Attack or Stroke that causes the subsequent claim occurs at least 30 days after the *life changing event* that caused the previous valid claim.

Note: Heart Attack and Stroke are treated as two different *life changing events*.

2. **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 *subsequent claims* – see table above

3. **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.

C4.8 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*.

C4.9 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 £3,000,000.

If *you* are also covered by other policies issued by *us*, the overall maximum amount that *we* will ever pay in respect of a *person covered* for Disability Cover for Business, Serious Illness Cover for Business, Serious Illness Cover Protector, Serious Illness Cover, Disability Cover, Family Income Cover payable on diagnosis of a *serious illness* and Education Cover payable on diagnosis of a severity A *serious illness* is £3,000,000. This overall maximum amount is increased to £4,000,000 if *your plan schedule* indicates that *you* have included Serious Illness Cover Booster.

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.

C4.10 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*

C4.11 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*
- The amount of *confirmed expenditure*

We will make a maximum of 12 monthly payments.

C5. 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.

C5.1 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 C5.7.

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 *plan* year is shown on *your plan schedule*. The maximum amount for subsequent *plan* 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 1st 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
  - 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 19th birthday
- The death of the *child*

If the *child* leaves a private school and enrols 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.

C5.2 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 University 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 C5.7.

We will pay the *benefit* if 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 *plan* year is shown on *your plan schedule*. The maximum amount for subsequent *plan* 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 1st 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
  - 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 25th birthday
  - The university fees *benefit* having been paid for five years
  - The death of the *child*

How much we will 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 we will 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.

C5.3 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, stationery, 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 C5.7.

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 (rounded to the next 0.25%) value five months before the start of the current school year. 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
- The death of the *child*

C5.4 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
- 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.

C5.5 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
- 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*.

C5.6 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. Serious Illness Cover Booster does not apply to this *benefit*.

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 one month old and has not reached the first *plan anniversary* after their 23rd birthday
- *Your child* is diagnosed with a *serious illness* as defined in Appendix 1
- 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

If *your* claim is for a *serious illness we* will usually assess using *functional activity tests*, or that is defined as total *permanent* disability (unable to do your own occupation ever again) *we* will assess your *child's* condition based on total *permanent disability* for *children* in Appendix 1.

See Appendix 1 for a list of conditions which require the use of *functional activity tests* to assess claims.

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 E.

SEVERITY LEVEL	THE PERCENTAGE OF YOUR COVER WE WILL PAY
A (most severe)	100%
B	75%
C	50%
D	25%
E	15%

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* 23rd birthday
- 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.

C5.7 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 *functional activity tests* to assess *your* claim. For more about *functional activity tests*, 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.

C5.8 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 the death or diagnosis of *terminal illness* happens after the Education Cover *date of expiry*. *Your plan schedule* shows this date.

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 *serious illness*.	Appendix 1
You suffer from a condition that *we* excluded from *your* cover after assessing *your* application.	*Your plan schedule*
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 *life-changing event* which caused *you* to claim.	Provision C5.7
You are making a *permanent* disability claim, and *you* do not survive until the date when *we* confirm that *you* are totally and *permanently* disabled.	Appendix 1
We do not receive written notice that *you* want to claim within six months of the *life-changing event* 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 C5.7
We are not satisfied that the *serious illness* that has lead 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 *life-changing event* which leads to *your* claim.	*Your plan schedule*

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 (including any payments as a result of Serious Illness Cover Booster) *benefit we* will pay for a *person covered* over the life of the *plan* is £3,000,000.

If *you* are also covered by other policies issued by *us*, the overall maximum amount that *we* will ever pay in respect of a *person covered* for Disability Cover for Business, Serious Illness Cover for Business, Serious Illness Cover Protector, Serious Illness Cover, Disability Cover, Family Income Cover payable on diagnosis of a *serious illness* and Education Cover payable on diagnosis of a severity A *serious illness* is £3,000,000. This overall maximum amount is increased to £4,000,000 if *your plan schedule* indicates that *you* have included Serious Illness Cover Booster.

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.

C5.9 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
- 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.

C6. 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.

C6.1 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.

A special definition means the loss of the physical ability through an illness or injury to do at least three of the six *tasks designed to assess whether you can look after yourself. We* list these tasks in provision D5.4. *We* use this definition to assess *house person* claims, see provision C6.6.

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
- Two months
- Three months
- Six months
- 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 or two months, *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 *benefit*s under Waiver of Premium on Incapacity Cover.

C6.2 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 period*s, see provision C6.1.

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* 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
- *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

C6.3 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 Vitality Optimiser, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser
- *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*
- *You* increase the amount of any of *your* covers

C6.4 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.

C6.5 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 previous claim
- Within three months of the original waiver of premium ending

C6.6 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 *house person*. *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 C6.1.

House person claims

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

- A *house person*
- A student
- Retired
- Working less than 16 hours a week
- *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 *house person* category if:

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

C6.7 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*
- Cancel *your plan*

C6.8 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.

C7. 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 Protected Life and Serious Illness Cover option, *you* cannot add this waiver to *your plan* if *you*:

- Only have Serious Illness Cover, at 100% of *your plan account*
- 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 Protected Life and Serious Illness Cover 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.

C7.1 When we will waive your plan premium

We will waive all further *plan* premium 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

C7.2 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.

C7.3 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 Vitality Optimiser, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser
- *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*
- *You* increase the amount of any of *your* covers

C7.4 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
- *You* are removed from the *plan*
- The *plan* is cancelled
- *Your* death

C8. WAIVER OF PREMIUM ON DEATH

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

C8.1 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* premium 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.

C8.2 When we will start waiving your plan premium

We will start waiving *your plan* premium from the date the *person covered* dies, or the date of the diagnosis of a *terminal illness*. However, *we* will not waive *your plan* premium if this date is after the *date of expiry* of the Waiver of Premium on Death

C8.3 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 Vitality Optimiser, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser
- *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*
- *You* increase the amount of *your* cover.

C8.4 When we will stop waiving your plan premium

We will stop waiving *your plan* premium 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*
- The *plan* is cancelled
- The death of the remaining *person covered*.

C9. PROTECTED COVER

C9.1 Protected Life and Serious Illness Cover

You can apply to add the Protected Life and Serious Illness Cover option to *your plan* if *you* have Serious Illness Cover.

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 Protected Life and Serious Illness Cover option.

C9.1.1 How the Protected Life and Serious Illness Cover option works

If *we* pay *you* a *benefit* under Serious Illness Cover *your plan account* will reduce by the amount of that *benefit*. If *your plan* includes the Protected Life and Serious Illness Cover option, *we* will top it back up. *We* do this as soon as *we* have paid all the *benefits* that are due as a result of *your* claim.

C9.1.2 When the Protected Life and Serious Illness Cover option ends

If *your plan* no longer has Serious Illness Cover *we* will remove the Protected Life and Serious Illness Cover 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.

C9.2 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.

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 either monthly or annually, in advance. *Your* selected payment frequency is shown in *your plan schedule*. If *you* have selected monthly, *your plan* premium will be paid for by direct debit. If *you* have selected annually, the *plan premium* will be paid for by either direct debit, Electronic Fund Transfer (EFT) or Telegraphic Transfers (TT).

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

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

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

If *you* do not pay *your 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* premium. 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. 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*.

After the *date of expiry* of *your* Serious Illness Cover and Life Cover, premiums will continue to be paid for *your* Later Life Option and Funeral Cover respectively. Please see provision C1.7 for information on how *your* premiums will continue.

D1.3 Indexed premium increases

If the *benefits* for any of *your* covers are indexed, *we* will increase *your* premiums annually. The amount by which *we* will increase *your* premiums will depend on *your* age at the time *your* cover increases. For *joint life plans* this will be based on the age of the younger of the two people covered.

If *you* have not reached the *plan anniversary* immediately before *your* 80th birthday the amount by which *we* increase *your* premiums also depend on the percentage rise in the *Retail Prices Index*, rounded to the next 0.25% at the time *your* cover increases.

Your premiums will increase in one of three ways:

THE PERCENTAGE INCREASE IN THE *RETAIL PRICES INDEX*	PREMIUM INCREASE AMOUNT
Above 0% up to and including 1.75%	Total of the percentage increase in the *Retail Prices Index* plus 1.5%
2% up to and including 7.75%	Total of the percentage increase in the *Retail Prices Index* plus 2.5%
8% and above	Total of the percentage increase in the *Retail Prices Index*, to a maximum of 10%, plus 3.5%

If the percentage change in the *Retail Prices Index* is 0% or less, then there will be no change in *your* cover amount or premium.

Once *you* have reached the *plan anniversary* immediately before *your* 80th birthday the premiums will increase by the total of:

- The percentage rise in the *Retail Prices Index* rounded to the next 0.25%, from a minimum of 0% to a maximum of 10%; and
- 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* one month 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 ask *us* not to apply indexation in any year. If *you* decline indexation, then *your* premium will not increase due to indexation for that year. If *you* do this for three consecutive years for any individual cover, *we* will cancel the indexation for that cover.

If *your* cover continues beyond *your* 80th birthday, then at the *plan anniversary* immediately before *your* 80th birthday (for *joint life plans* this will be based on the age of the younger of the two people covered) *we* will write to *you* and ask *you* to confirm whether *you* want *your* covers to continue to be indexed. If *you* do not tell *us you* want *your* covers to continue to be indexed, *we* will cancel indexation on *your plan* and *your* premiums and cover amounts will no longer increase due to indexation.

There will be no change to *your* premiums or *your* cover amounts if *we* cancel indexation. If *we* have removed indexation, *you* can apply for *us* to reintroduce it. However, *we* will need to repeat the *underwriting* process for all the *persons covered*.

D1.4 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.

For *joint life plans*, *we* will reduce *your* premium if *you* make a claim for Serious Illness Cover. *We* do this because the claim reduces the amount of *your benefits*. *We* reduce the premium in proportion to the reduction in *your benefits*. *We* will reduce the premium for the person who did not claim if their cover reduces.

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

D1.5 How your Vitality Status, or both your Vitality Status and your Wellness Status, affect your plan premiums

Your plan premium may change as a result of *your Vitality Status,* or both *your Vitality Status* and *your Wellness Status*. *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 *your Vitality Status, or both your Vitality Status and your Wellness Status,* after any changes that result from indexation, a review of *your* premiums, or if *you* have chosen Premium Optimiser or Interest Rate Optimiser.

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

For more about how *your Vitality Status* may affect *your plan* premium, see provision E2.

For more about how Wellness Optimiser may affect *your* premium, see provision E3.

D1.6 Premium Optimiser

Premium Optimiser is only available if *you* have selected *Whole of Life* Cover, with or without LifestyleCare Cover, and guaranteed premiums (see provision D2).

With Premium Optimiser *your* initial *Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium starts lower than an equivalent *Whole of Life* premium that does not include Premium Optimiser.

At each *plan anniversary your Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium will increase by 2.5%.

We will apply any change in *your Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium as a result of Premium Optimiser before any change as a result of indexation or *your Vitality Status*, or both *your Vitality Status* and *your Wellness Status*. *Your Plan Schedule* indicates whether *you* have chosen Premium Optimiser.

D1.7 Interest Rate Optimiser

Interest Rate Optimiser is only available if *you* have selected *Whole of Life* Cover, with or without LifestyleCare Cover, and guaranteed premiums (see provision D2).

With Interest Rate Optimiser *your* initial *Whole of Life* Cover or *Whole of Life* Cover with LifestyleCare Cover premium starts lower than an equivalent *Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium that does not include Interest Rate Optimiser.

At each *plan anniversary your Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium will increase.

Your Whole of Life Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium increase will depend on the *Long Term Interest Rate* that is published on the first working day of the calendar quarter 65 days before *your plan anniversary* e.g. 1st January.

The table below shows how *your* annual *Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premiums can change:

LONG TERM INTEREST RATE	PREMIUM INCREASE
2% or lower	2.75%
2.25%	2.6875%
2.50%	2.625%
2.75%	2.5625%
3%	2.5%
3.25%	2.375%
3.50%	2.25%
3.75%	2.125%
4%	2%
4.25%	1.875%
4.50%	1.75%
4.75%	1.625%
5%	1.5%
5.25%	1.375%
5.50%	1.25%
5.75%	1.125%
6% or higher	1%

We will apply any change in *Whole of Life* Cover, or *Whole of Life* Cover with LifestyleCare Cover, premium as a result of Interest Rate Optimiser before any change as a result of Indexation or *your Vitality status*.

Your Plan Schedule indicates whether *you* have chosen Interest Rate Optimiser. Further information regarding the *Long Term Interest Rate* can be found at vitality.co.uk/wholeoflife.

D2. GUARANTEED PREMIUMS

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

D2.1 A guaranteed premium is one that will only change;

- If *you* change *your plan*
- If *you* make a claim
- Depending on *your Vitality Status,* or both *your Vitality Status* and *your Wellness Status* (See provision E)
- If *your* premiums are indexed
- At each *plan anniversary* if *you* have chosen either Premium Optimiser (See D1.6) or Interest Rate Optimiser. (See D1.7)

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
- 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 Vitality Optimiser or Wellness Optimiser (see Provision E) this does not count as a review.

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 70th 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 75th 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 one month 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	*You* do not need to do anything
	Keep *your* current premium and have less cover	Tell *us* in writing within 30 days of receiving *our* notification. If *your* current premium is below *our* allowable minimum, *we* will ask *you* to increase *your* premium to the minimum level.
	Cancel *your* cover	For how to cancel a cover, see provision F
Decrease	Accept the decreased premium	*You* do not need to do anything
	Ask to keep *your* current premium and have more cover	Apply to *us* in writing within 30 days of receiving *our* notification. *We* may need to *underwrite your* request.
	Cancel *your* 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*
- Change the *fixed term* of *your* covers
- Change *your deferred period*
- Lower *your* premiums because of a change in *your* circumstances
- Remove Vitality Optimiser
- Remove Premium Optimiser
- Remove Wellness Optimiser
- Remove Interest Rate Optimiser

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
- *You* cannot increase *your* Later Life Option or *your* Funeral Cover amount once the cover has started
- *You* cannot increase *your* Later Life Option or *your* Funeral Cover amount if the remaining term on *your* Serious Illness Cover or *your* Life Cover is below the minimum required *plan* term
- *You* cannot add any Later Life Options on more than one policy *you* are covered on

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 changes to *your* premium due to *your Vitality Status,* or both *your Vitality Status* and *your Wellness Status*
- Any changes to *your* premium due to Premium Optimiser or Interest Rate Optimiser
- Any changes to *your* premium due to indexation

Reducing a cover might also reduce other covers in *your plan*. *Your* premiums might also change. For more about this, see provision D1. For information on how *your* premium will change if *you* remove Vitality Optimiser, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser see provision D4.6, D4.7 and 4.8.

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 first death 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 Vitality Optimiser, Wellness Optimiser, Premium Optimiser, Interest Rate Optimiser, 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 Protected Life and Serious Illness Cover option, if *you* have it, so that it reflects the new value of the *plan account*
- Remove the Protected Life and Serious Illness Cover option altogether if Life Cover is the only cover left in the *plan account*

D4.4 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* have a Later Life Option or Funeral Cover and *you* reduce *your* Serious Illness Cover term below the minimum required *plan* term, *your* Later Life Option and Funeral Cover will be removed from *your plan*.

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.

D4.5 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
- 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.

D4.6 Removing Vitality Optimiser

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

You are only eligible for Vitality Optimiser under this *plan* if *you* also have *Vitality Plus* or *Vitality Select*. For more information on *Vitality Plus* or *Vitality Select* please see *your* separate terms and conditions. If *your Vitality Plus* or *Vitality Select* is cancelled, Vitality Optimiser will be removed from *your plan*.

If Vitality Optimiser is removed *your* premiums will change as follows:

- If *you* want to keep *your* premium at the same level until the *date of expiry*, the level of cover will be reduced. *We* will calculate the new level of cover for each of the covers in *your plan*.
- If *you* want to keep *your benefit* at the same level until the *date of expiry*, the premium will increase. *We* will calculate the premium for each of the covers in *your plan*.

If *you* have *Vitality Select* and *you* remove Vitality Optimiser, *your Vitality Select* will also be removed from *your plan*.

If *you* have *Vitality Plus* and remove Vitality Optimiser from *your plan, your Vitality Plus* will remain in place, unless *you* separately cancel it. The fee charged for *Vitality Plus* may also change.

If *you* have a Later Life Option or Funeral Cover and *you* remove Vitality Optimiser from *your plan*, *your* cover will be affected as follows:

- If *you* remove Vitality Optimiser during *your* Serious Illness Cover term, *your* Later Life Option and Funeral Cover will be removed from *your plan*.
- If *you* remove Vitality Optimiser after cover under *your* Later Life Option or Funeral Cover has begun, the *plan* will continue subject to an increase in the premium.

D4.7 Removing Wellness Optimiser

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

You are only eligible for Wellness Optimiser under this *plan* if *you* also have *Vitality Plus* or *Vitality Select*. For more information on *Vitality Plus* or *Vitality Select*, please see *your* separate terms and conditions. If *your Vitality Plus* or *Vitality Select* is cancelled, Wellness Optimiser will be removed from *your plan*.

If Wellness Optimiser is removed, *your plan* will change as follows:

- *You* can keep *your* premium at the same level and reduce *your* level of cover
- *You* can keep *your* cover amounts at the same level and *your* premium will increase.

If *you* have *Vitality Select* and *you* remove Wellness Optimiser, *your Vitality Select* will also be removed from *your plan*.

If *you* have *Vitality Plus* and remove Wellness Optimiser from *your plan, your Vitality Plus* will remain in place, unless *you* separately cancel it. The fee charged for *Vitality Plus* may also change.

The fee charged for *Vitality Plus* may also change.

If *you* have a Later Life Option or Funeral Cover and *you* remove Wellness Optimiser from *your plan*, *your* cover will be affected as follows:

- If *you* remove Wellness Optimiser during *your* Serious Illness Cover term, *your* Later Life Option and Funeral Cover will be removed from *your plan*.
- If *you* remove Wellness Optimiser after cover under *your* Later Life Option or Funeral Cover has begun, the *plan* will continue subject to an increase in the premium.

D4.8 Removing Premium Optimiser or Interest Rate Optimiser

If *your plan schedule* shows that *you* have chosen Premium Optimiser or Interest Rate Optimiser, *you* can apply to remove these options at any time.

If Premium Optimiser or Interest Rate Optimiser are removed *your* premiums will change as follows:

- If *you* want to keep *your* premium for *Whole of Life* Cover or *Whole of Life* Cover with LifestyleCare Cover at the same level, the level of cover will be reduced.
- If *you* want to keep *your Whole of Life* Cover or *Whole of Life* Cover with LifestyleCare Cover *benefit* at the same level, the premium will increase.

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, Family Income Cover or *Children's* Funeral Contribution 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.

For the purposes of complying with *our* Anti-Money Laundering obligations, *we* may require a claim recipient to give *us* satisfactory proof of their identity.

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*. *You* must need the help or supervision of another person and be unable to perform the task on *your* own even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication. *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*:

- *Tasks designed to assess whether you can look after yourself* (*we* also refer to these as *activities of daily living* in these *plan* provisions)
- *Work Tasks*

Types of functional activity tests

TASKS DESIGNED TO ASSESS WHETHER YOU CAN LOOK AFTER YOURSELF EVER AGAIN (ALSO CALLED ACTIVITIES OF DAILY LIVING)	HOW WE DEFINE THIS ACTIVITY
Washing	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
Getting dressed and undressed	The ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
Feeding yourself	The ability to feed *your*self when food has been prepared and made available.
Maintaining personal hygiene	The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
Getting between rooms	The ability to get from room to room on a level floor.
Getting in and out of bed	The ability to get out of bed into an upright chair or wheelchair and back again.

WORK TASKS	HOW WE DEFINE THIS ACTIVITY
Walking	The ability to walk more than 200 metres on a level surface.
Climbing	The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.
Lifting	The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.
Bending	The ability to bend or kneel to touch the floor and straighten up again.
Getting in and out of a car	The ability to get into a standard saloon car, and out again.
Writing	The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

For the above definitions, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

Knowing which tests are relevant to your claim

The specific tests *you* need to take will depend on the cover *you* are claiming under.

Serious Illness Cover

If *you* are aged between 16 and 65 when *you* make *your* claim *we* will assess *your* claim based on whether *you* can perform *activities of daily living* or *work tasks*. When *we* assess whether *you* are incapacitated there will be no accumulation of the number of failures for *tasks designed to assess whether you can look after yourself* and *work tasks*. *We* will assess each set of tasks separately and 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 aged 65 or over when *you* make *your* claim *we* will assess *your* claim based on whether *you* can perform *activities of daily living*.

If *your claim* is for *your child* under Optional Serious Illness Cover for *Children*, *we* will assess *your child's* disability level based on the reports from the consultant in charge of monitoring *your child's* progress.

Income Protection, Waiver of Premium on Incapacity or Disability Cover

If *you* have the special definition of incapacity or *you* are a *House person* then *we* will assess *your* claim based on whether *you* can perform *activities of daily living*. The tests *you* will need to take are also explained 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 specialist*s 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
- LifestyleCare Cover
- Later Life Options

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*.

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 Income Protection Cover

We will not pay the *benefit* if the *life-changing event* that causes *you* to claim happens before the *start date* of *your* Income Protection Cover.

Exclusions for LifestyleCare Cover

Appendix 4 explains the exclusions that apply to claims for specific illnesses or conditions under LifestyleCare Cover.

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 4. 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* LifestyleCare Cover. If *we* have, and *you* make a claim, *we* will not pay a *benefit* if *our* Chief Medical Officer believes that *your* 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 3 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
- The date the *plan* was re-instated if it was suspended because *your plan* premiums were not paid.

Exclusions for Family Benefit

We will not pay the *benefit* if:

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

In addition, no claim can be made for Complications of Pregnancy or Specified Congenital Conditions until *your* Serious Illness Cover has been in force for at least nine months.

Exclusions for Later Life Options

Appendix 5 explains the exclusions that apply to claims for specific illnesses under Later Life Options.

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 5.1. 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*.

If *you* to claim for a condition under Serious Illness Cover, *you* will not be able to claim for that condition, or any related conditions, under Later Life Options. Related conditions are listed in Appendix 5.2.

We may have excluded specific conditions from *your* Later Life Option. If *we* have, and *you* make a claim, *we* will not pay a *benefit* if *our* Chief Medical Officer believes that *your* illness or condition 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* Serious Illness Cover. Additionally, *we* will base any *benefit* on the cover amount that was in force at the time the condition, which *you* are claiming for, occurred.

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 Vitality Optimiser, Wellness Optimiser, Premium Optimiser or Interest Rate Optimiser 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 C8.

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

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*
- Remove Optional Serious Illness Cover for *Children* if there are no core covers left on the *plan*
- Remove the Protected Life and Serious Illness Cover option if there is no Serious Illness Cover 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

Serious Illness Cover will continue for the surviving *person covered* if the *plan account* has not reduced to zero after the Life Cover claim. The Serious Illness Cover amount for the surviving *person covered* will be calculated by subtracting the total amount paid for the Life Cover claim from the *plan account* immediately prior to the claim. The amount of Serious Illness Cover will be the chosen percentage of the *plan account*.

If the surviving person wants to increase their cover, *we* will need to *underwrite* their request. The *plan premium* will be calculated using premium rates applicable at the time of the request. Additionally, the *plan* will be subject to the provisions applicable at the time of the 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*. This request is subject to *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 *plan* 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 C8.

E. HOW VITALITY REWARDS YOU FOR BEING HEALTHY

The *Vitality Programme* helps *you* improve *your* health – and saves *you* money at the same time. *Vitality* encourages *you* to be healthy by offering all adults on the *plan* discounts with a range of health partners. By taking steps to look after *your* health, *you* can increase *your Vitality Status*. To begin with, this is Bronze. Then as *you* make an effort to be healthy, *you* can increase *your Status* to Silver, Gold or even Platinum. The higher *your Status*, the greater the discounts and rewards. Some Vitality rewards and *benefits* are only available to those who are over the age of 18.

The *Vitality Programme* is provided to *you* by Vitality Corporate Services Limited.

Please refer to the separate terms and conditions for more information on the *Vitality Programme*.

E1. YOUR VITALITY STATUS

When *you* take steps to look after *your* health, *you* could improve *your Vitality Status*. There are four *Vitality Statuses*:

VITALITY STATUS	EFFORT THRESHOLD
BRONZE	*You* start at this level on *your plan's start date*. *You* may return to this level on each *plan anniversary*, depending on the *Vitality Status* rules at the time.
SILVER	*You* will be able to achieve silver *Vitality Status* between *plan anniversaries* if *you* make a moderate but regular effort to look after *your* health.
GOLD	*You* will be able to achieve gold *Vitality Status* between *plan anniversaries* if *you* make a strong and regular effort to look after *your* health.
PLATINUM	*You* will be able to achieve platinum *Vitality Status* between *plan anniversaries* if *you* make a very strong and regular effort to look after *your* health.

E2. VITALITY OPTIMISER

With Vitality Optimiser *your* initial *plan premium* starts lower than an equivalent *plan* that does not include Vitality Optimiser and *your plan premium* may change on each *plan anniversary*. *Your plan schedule* indicates whether *you* have chosen Vitality Optimiser.

Vitality Optimiser can be added at any time during the term of *your plan* and once added, will automatically include *Vitality Benefits* - either *Vitality Plus* or *Vitality Select* on *your plan*. Please see provision E4 for more information on *Vitality Benefits*.

We will recalculate *your plan premium* on each *plan anniversary* until the *date of expiry* of each cover.

E2.1 How we calculate the change in your plan premium

Where you have chosen Vitality Optimiser we will recalculate *your plan premium* based on *your Vitality Status* at *plan anniversary*. The following table shows *you* how *your plan premium* can change:

VITALITY STATUS	PREMIUM CHANGE
BRONZE	+2%
SILVER	+1%
GOLD	No change
PLATINUM	-1%

If the premiums for *your* covers change, the premiums for any waiver or premium cover could also change (see provision D1).

The premium changes in this table do not apply if *you* have Wellness Optimiser and *you* are below age 70. For more information on how Wellness Optimiser affects *your* premiums, see provision E3. After the *person covered* reaches age 70, *their plan premium* will change in the same way that a *plan* with Vitality Optimiser would change.

We will apply any change in premium as a result of Vitality Optimiser after any changes as a result of indexation, Premium Optimiser, Interest Rate Optimiser or a review of *your* premiums. This table does not apply if *you* have Wellness Optimiser. For more information on how Wellness Optimiser affects *your* premiums, see provision E3. For more about how indexation could affect *your* premiums, see provisions D1.3. For more about how a review of *your* premiums could affect *your* premiums, see provision D3. For more information about how Premium Optimiser or Interest Rate Optimiser could affect *your* premiums, see provision D1.6 and D1.7.

The maximum amount your premium can reduce

The maximum premium reduction *you* can have due to Vitality Optimiser on each of *your* covers, over their respective terms, is 5%. This means *your plan premium* for each cover can only ever reduce by a maximum of 5% compared to *your plan premium* at the start of *your* cover with Vitality Optimiser. If *you* have a *joint life plan,* this will apply to each *person covered*.

This maximum premium reduction only applies to premium changes due to Vitality Optimiser. It excludes:

- The upfront discount *you* receive due to Vitality Optimiser
- Any changes *you* make to *your* cover or *plan*
- Any premium changes that may also apply due to indexation, a review of *your* premium, or if *you* have chosen Interest Rate Optimiser or Premium Optimiser
- Any proportional premium reductions that may apply due to *your* Later Life Option or Funeral Cover being greater than the maximum amount.
- Once cover under *your* Later Life Option begins, reducing *your* Comprehensive Serious Illness Cover premium to that of Primary Serious Illness Cover.

You will not be eligible for a further 5% reduction in *your plan* premium due to Vitality Optimiser once cover under *your* Later Life Option or Funeral Cover begins.

E3. WELLNESS OPTIMISER

With Wellness Optimiser, *your* initial *plan* premium starts lower than the premium of an equivalent *plan* that does not include Wellness Optimiser.

Wellness Optimiser can be added at any time during the term of *your plan* and once added, will automatically include *Vitality Benefits* - either *Vitality Plus* or *Vitality Select* on *your plan*. Please see provision E4 for more information on *Vitality Benefits*.

At each *plan anniversary your* premiums will change according to both *your*:

- *Wellness Status,* and
- *Vitality Status*

Please see provision E1 for details regarding *your Vitality Status.*

E3.1 Your Wellness Status

There are three *Wellness Statuses*:

- Select
- Healthy
- Everyday

Your Wellness Status is based on *your* clinical health factors. Please see *your* Vitality Terms and Conditions for information on how *we* define *your Wellness Status*.

E3.2 How your Wellness Status and Vitality Status affect your plan premium

The following table shows *you* how *your plan premium* can change each year depending on *your Wellness Status* and *your Vitality Status*.

WELLNESS STATUS	VITALITY STATUS			
	BRONZE	SILVER	GOLD	PLATINUM
SELECT	+2%	+1%	0%	-1%
HEALTHY	+3%	+2%	+1%	0%
EVERYDAY	+4%	+3%	+2%	+1%

Your plan premium will change at each *plan anniversary* depending on both *your Vitality Status* and *your Wellness Status* until the *plan anniversary* immediately before *your* 70th birthday. After *your* 70th birthday, *your plan premium* will only change by *your Vitality Status* at each *plan anniversary*. If *you* have a *joint life plan*, this will affect each person separately. This means for each *person covered*, their Wellness Optimiser premiums will only change by their *Vitality Status* at each *plan anniversary* after their 70th birthday. This will work the same way as Vitality Optimiser works. Please see provision E2.1 'How *we* calculate the change in *your plan* premium' for more information on this.

If *you* have Optional Serious Illness Cover for *Children*, premium changes due to Wellness Optimiser for this cover will be based on the *planholder's Wellness Status* and *Vitality Status*. If *you* have a *joint life plan*, the *planholder* is the *first person covered*.

The maximum amount your premium can reduce

The maximum premium reduction *you* can have due to Wellness Optimiser on each of *your* covers, over their respective terms, is 5%. This means *your plan premium* for each cover can only ever reduce by a maximum of 5% compared to *your plan premium* at the start of *your* cover with Wellness Optimiser. If *you* have a *joint life plan*, this will apply to each *person covered*.

This maximum premium reduction only applies to premium changes due to Wellness Optimiser. It excludes:

- The upfront discount *you* receive due to Wellness Optimiser
- Any changes *you* make to *your* cover or *plan*
- Any premium changes that may also apply due to indexation, a review of *your* premium, or if *you* have chosen Interest Rate Optimiser or Premium Optimiser
- Any proportional premium reductions that may apply due to *your* Later Life Option or Funeral Cover being greater than the maximum amount.
- Once cover under *your* Later Life Option begins, reducing *your* Comprehensive Serious Illness Cover premium to that of Primary Serious Illness Cover.

You will not be eligible for a further 5% reduction in *your plan* premium due to Wellness Optimiser once cover under *your* Later Life Option or Funeral Cover begins.

E3.3 When your premium will not increase

If *you* get a *serious illness* that *we* class as Severity A, *we* will not increase *your plan premium* due to Wellness Optimiser. However, if *you* are eligible for a premium reduction, *we* will continue to apply this to *your plan premium*. *You* do not need to have Serious Illness Cover for this to apply.

Your plan premium may continue to increase if *you* have selected indexation, Premium Optimiser or Interest Rate Optimiser, or due to a review of *your* premiums.

Please see Appendix 1 for a full list of the severity A *serious illnesses we* cover. Please see provision D1.3 for more information on how *your plan premium* changes due to indexation, D1.6 for how *your plan* premiums change due to Premium Optimiser, or D1.7 for how *your plan premium* changes due to Interest Rate Optimiser. Please see provision D3 for more information on reviewable premiums.

E4. VITALITY BENEFITS ON YOUR PLAN

E4.1 Vitality Benefits for plans without Vitality Optimiser or Wellness Optimiser

For *plans* without Vitality Optimiser or Wellness Optimiser, *you* are able to add *Vitality Plus* to *your plan*. *You* can choose to include *Vitality Plus* on *your plan* from the *plan's start date*, or within three months of the *plan's start date*. Outside of this period, *Vitality Plus* can only be added at each anniversary of the *plan*.

You will be subject to a minimum *plan premium* to add *Vitality Plus* to *your plan*. Please contact *your* financial advisor for further details.

E4.2 Vitality Benefits for plans with Vitality Optimiser or Wellness Optimiser

For both Vitality Optimiser and Wellness Optimiser *your plan* will automatically include *Vitality Benefits* - either *Vitality Plus* or *Vitality Select*. *Your plan schedule* indicates whether *your plan* includes *Vitality Plus* or *Vitality Select*.

Your initial plan premium will define which *Vitality Benefits your plan* includes, either *Vitality Plus* or *Vitality Select*. If *your initial plan premium* is:-

- Below £45* for a *single life plan* or £60* for a *joint life plan* then *Vitality Select* will automatically be included on *your plan*,
- £45* or above for a *single life plan* or £60* or above for a *joint life plan* then *Vitality Plus* will automatically be included on *your plan*.

** This is the current initial plan premium that determines which Vitality Benefits (Vitality Plus or Vitality Select) you will receive on your plan. This applies to all plans that have selected Vitality Optimiser or Wellness Optimiser now. If you later choose to add Vitality Optimiser or Wellness Optimiser, the premium requirements which determine your Vitality Benefits may have changed.*

E4.3 How my Vitality Benefits may change during the duration of my plan

There will be no change to *your Vitality Benefits* as a result of a change to *your* premiums for any of the following:-

- *Vitality status* premium adjustments, or
- *Wellness status* premium adjustments, or
- Indexation, or
- Premium Optimiser adjustments, or
- Interest Rate Optimiser adjustments, or
- Review of *your* premiums, or
- Existing covers expire, or
- A valid claim on existing cover.

However, the *Vitality Benefits you* have access to may change if *you* make one or more of the following changes to *your plan*:-

- Add or increase covers,
- Remove or reduce covers,
- Remove a *person covered* from a *joint life plan* or add a *person covered* to *your* existing *plan*,
- Change the *fixed term* of *your* covers,
- Change *your deferred period*,
- Reduce *your* premiums because of a change in *your* circumstances.

The *Vitality Benefits you* have access to will only change if, as a result of one of the above, *your plan premium* changes. This will only happen in one of following ways:-

1. *Your plan* is a Vitality Optimiser or Wellness Optimiser *plan* including *Vitality Select* and *you* make a change to *your plan* such that *your plan premium* increases to £45* (single life) or £60* (joint life) or more. In this case *Vitality Select* would be removed from *your plan* and replaced with *Vitality Plus*.
2. *Your plan* is a Vitality Optimiser or Wellness Optimiser *plan* including *Vitality Plus* and *you* make a change to *your plan* such that *your plan premium* reduces below £45* (single life) or £60* (joint life). In this case *Vitality Plus* would be removed from *your plan* and replaced with *Vitality Select*.
3. *Your plan* includes *Vitality Plus* (and is not a Vitality Optimiser or Wellness Optimiser *plan*) and *you* make a change to *your plan* such that *your plan premium* reduces below £45* (single life) or £60* (joint life). In this case *Vitality Plus* would be removed from *your plan*.

** This is the current initial plan premium that determines which Vitality Benefits (Vitality Plus or Vitality Select) you will receive on your plan. This applies to all plans that have selected Vitality Optimiser or Wellness Optimiser now. If you later choose to add Vitality Optimiser or Wellness Optimiser, the premium requirements which determine your Vitality Benefits may have changed.*

E4.4 Cancelling your Vitality Benefits

E4.4.1 Vitality Select

If *your Vitality Select* is cancelled, Vitality Optimiser or Wellness Optimiser will be removed from *your plan* and *your* premiums will change as described in provision D4. Please refer to the separate terms and conditions for more information on the *Vitality Programme*.

If *you* cancel *Vitality Select, you* may not be able to add it again to *your plan* after it has been cancelled.

E4.4.2 Vitality Plus

If *your plan* is not a Vitality Optimiser or Wellness Optimiser *plan* and *Vitality Plus* is cancelled, it will be removed from *your plan* and there will be no change to *your* premiums.

If *your plan* is a Vitality Optimiser or Wellness Optimiser *plan* and *your Vitality Plus* is cancelled, Vitality Optimiser or Wellness Optimiser will be removed from *your plan* and *your* premiums will change as described in provision D4. If *you* remove Vitality Optimiser or Wellness Optimiser from *your plan, your Vitality Plus* will continue in place, unless *you* separately cancel it. The fee charged for *Vitality Plus* may also change. Please refer to the separate terms and conditions for more information on the *Vitality Programme*.

If *you* cancel *Vitality Plus you* can apply to add it again at a future *plan anniversary*, provided that *you* do this at least six months after the date *Vitality Plus* was cancelled. However, *you* may not be able to add Vitality Optimiser or Wellness Optimiser to *your plan* again after it has been removed.

E5. THE VITALITY COMMITMENT

The *Vitality Programme* will give *you* access to discounts and rewards for the duration of *your plan*. Because *your plan* could last many years, the discounts and rewards offered to *you* may need to be revised from time to time.

As new opportunities and technologies emerge, the way *you* are rewarded for being healthy will change over time. The discounts and rewards depend on the relationships with third party providers and the range of services these providers offer.

Please refer to the separate terms and conditions for more information on the *Vitality Programme*. This includes changes to the way *you* are awarded Vitality points, the eligible activities, incentives and partners offered, and how *your Vitality Status* could change as a result.

If *you're* not satisfied with the changes, *you* may cancel *your plan* in accordance with the information in provision F3.

If *you* would like full details of the discounts and rewards that are in effect at any time, please call 0345 601 0072.

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 Protected Life and Serious Illness Cover option, or any Disability Cover or Income Protection Cover as part of *your plan* at that time
- All covers under *your plan* have reached their *date of expiry*
- *You* cancel *your* plan

F2. WHEN WE CAN MAKE CHANGES TO YOUR PLAN

We may change the terms of *your Plan* for any of the following reasons:

a. To respond, in a proportionate manner, to changes in the way *we* administer *plans* of this type.

b. To respond, in a proportionate manner, to changes in technology or general practice in the life and pensions industry.

c. To respond, in a proportionate manner, to changes in taxation, the law or interpretation of the laws of England and Wales, decisions or recommendations of an Ombudsman, regulator, *UK* Court, the European Court of Justice, or similar person, or any code of practice with which *we* intend to comply (with the exception of Guaranteed Premiums, unless such change is required by the Financial Services Regulator from time to time).

If *we* consider any variation to these conditions is to *your* advantage or is necessary to meet regulatory requirements, *we* may make the change immediately and will tell *you* at a later date.

We will tell *you* in writing of any change *we* consider is to *your* disadvantage (other than any change necessary to meet regulatory requirements) at least 60 days before the change becomes effective, unless it is not possible for *us* to do this, in which case *we* will give *you* as much notice as *we* can.

F3. CANCELLING YOUR PLAN

When you may cancel your plan

You can cancel *your plan* at any time.

If *you* cancel within 30 days of receiving *your plan* details, *we* will refund *your plan* premium, as long as *you* have not made a claim.

If *you* pay *your* premiums monthly and *you* cancel *your plan* after 30 days, *we* will not refund *your plan* premium.

If *you* pay *your* premiums annually and *you* cancel *your plan* after 30 days, *we* will calculate *your* premium as though it were monthly and will refund *you* for the remainder of the *plan year* from the cancellation date.

To cancel *your plan*, *you* will need to contact *us* via one of the following methods:

Phone:	0800 030 4903
Email:	VitalityLife_CreditControl@vitality.co.uk
Post:	VitalityLife, Sheffield, S95 1BW

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
- Act fraudulently in any other way

If *we* cancel *your plan* because of fraud, *your plan* will become void.

OTHER REASONS

The Financial Conduct Authority (FCA) publishes an Insurance 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 FCA may update their rules during the life of *your plan*. For the latest rules, please contact the FCA at consumer.queries@fca.gov.uk or by phoning 0800 111 6768. *You* can also download the Conduct of Business Sourcebook at www.fca.org.uk

F4. CASH VALUE

Your plan does not have any cash value.

F5. 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.

F6. 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: Vitality Life Limited, Sheffield, S95 1BW.

We will not change who is entitled to *benefit*s under *your plan* until *we* receive this notice.

F7. PAYMENTS AND CURRENCY

All payments *we* make to *you* will be to a bank account registered in the *United Kingdom*. In addition, all payments made to *us* must be from a bank account registered in the *United Kingdom*. *You* must also be the registered account holder of the bank account; alternatively there must be an *insurable interest* between *you* and the registered account holder of this bank account.

We cannot make any payments to *you*, nor accept any payments from *you* if the bank account is registered outside the *United Kingdom*.

All payments must be in pound sterling (GBP).

F8. IMPACT ON MEANS TESTED BENEFITS

Payments of *benefits* from this plan, including LifestyleCare cover, may affect *your* entitlement to receive means tested *benefits* from the government or *your* local authority. *We* recommend that *you* seek professional advice if *you* are concerned about this.

F9. COMPLAINTS

Our commitment to you

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

How to contact us

You can contact *us* by letter, phone or email. It will help if *you* give *your* name, address and *plan* number. Either send *us* a secure message via *our* Member Zone or call *us* on the number shown on *your* certificate of insurance. Or *you* can write to *us* at:

VitalityLife Customer Services, Sheffield, S95 1BW

How we will deal with your complaint

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

We will:

- Acknowledge *your* complaint promptly
- Tell *you* who is dealing with *your* complaint so contacting *us* is easier. This person will be a trained complaint handler not directly involved with *your* case before the complaint
- Fully investigate *your* complaint and send *you* a detailed report about *our* findings. *We* will clearly explain the reasons behind *our* decision and what action *we* will take to put things right, if appropriate
- Update *you* every four weeks if the investigation is not complete and explain the reason for the delay

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

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

The Financial Ombudsman Service is an impartial adjudicator and provides a free, independent service for resolving disputes with financial services firms. If *you* are going to ask the Financial Ombudsman to review *your* case, *you* should do so within six months of *our* giving *you our* final decision on *your* complaint.

You can contact the Financial Ombudsman in the following ways:

The Financial Ombudsman Service
Exchange Tower,
London, E14 9SR
Enquiry line: 0800 023 4567
Fax number: 020 7964 1001
Website: www.financial-ombudsman.org.uk
Email: complaint.info@financial-ombudsman.org.uk

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

F10. IF WE CANNOT MEET OUR OBLIGATIONS

We are covered by the Financial Services Compensation Scheme (FSCS). *You* may be entitled to compensation from the scheme if *we* cannot meet *our* obligations. Whether or not *you* are able to claim and how much *you* may be entitled to will depend on the specific circumstances at the time.

For further information about the scheme please contact the FSCS at: www.fscs.org.uk.

F11. INSURABLE INTEREST

You must have an *insurable interest* in the *person covered* when *you* take out the *plan*. If *insurable interest* does not exist, *your plan* will become void.

F12. 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*.

Sanctions

We will not be responsible or liable to make any payment to *you* or any third party covered under *your plan* howsoever arising (including, but not excluding, payment of any *benefit*) when doing so would put *us* in breach of any applicable economic sanctions, laws and regulations of the European Union, the *United Kingdom*, the United Nations or any other legal regime or code of practise *we* may consider applicable.

Economic sanctions are subject to changes and include prohibiting the transfer of funds to a sanctioned country, freezing the assets of a government, the corporate entities and residents of a sanctioned country, or freezing the assets of specific individuals or corporate entities.

If *you*, or any third party who is covered under *your plan*, are the subject of sanctions, *we* may not be able to provide cover under *your plan* and *we* may terminate *your plan* with *us*.

F13. DATA PROTECTION NOTICE

Why should you read this notice?

We think it is important for all of *our* members to be made aware of what information Vitality holds about them and to have the reassurance of knowing that *we* comply with the data protection legislations. The following is a summary of *our* Privacy Policy. For details of the full Privacy Policy (effective from 25 May 2018) please visit vitality.co.uk/privacy.

Who Vitality are

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

Vitality Corporate Services Limited is an authorised intermediary of Vitality

Health Limited ("VitalityHealth"), Vitality Life Limited ("VitalityLife") and ("VitalityInvest"). Together "Vitality" arranges and administers products provided by VitalityHealth, VitalityLife and VitalityInvest. Vitality Corporate Services Limited is the data controller for the management of interactions between *us* and *you*; VitalityHealth and VitalityLife and VitalityInvest respectively are the data controllers for the personal data and special category data that *you* or *your* representative provide to *us*.

Sharing your personal data

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

Processing claims

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

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

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

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

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

Marketing

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

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

You can manage *your* marketing preferences and choose *your* preferred method of receiving information about *our* products, services and the *benefits* at any time by calling *our* customer services team.

Data protection complaints

We want all of *our* members to be happy with the way their personal data, health data and medical information has been processed by *us*. If *you* are unhappy about the way *we* have managed *your* personal data *we* would like to know about it as *we* are constantly striving to ensure *we* do the right thing and *we* would like to be able to put things right.

You'll find the contact details for *our* complaints teams at:

vitality.co.uk/legal/complaints

However, if *you* are still dissatisfied *you* have the right to contact the Information Commissioner, who regulates compliance with data protection regulation and laws at:

ico.org.uk

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

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

If *you* have any queries in respect of *your* data protection rights or the way *your* personal data is processed by Vitality, please call *us* on 0207 133 8600, or write to *us* at:

Data Protection Officer
Vitality
70 Gracechurch Street
London
EC3V 0XL

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

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 (ALSO REFERRED TO AS TASKS DESIGNED TO ASSESS WHETHER YOU CAN LOOK AFTER YOURSELF)

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.

ADOPTION

For a *single life plan*, the legal *adoption* of a *child* or *children* by the *Person Covered*.

For a *joint life plan*, the legal *adoption* of a *child* or *children* by both people covered.

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 any of the *Permitted countries*
- Not related by blood or *marriage* to the person or people covered
- 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 the appendices.

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:

- Has not reached the first *plan anniversary* after their 18th birthday (23rd birthday if they are in full-time education), and
- Is *your* natural *child*, adopted *child* or *step-child*, and
- Is looked after by, or financially dependent on, *you*.

CHILDBIRTH

For a *single life plan*, the birth of a *child* or *children* to the *person covered*.

For a *joint life plan*, the birth of a *child* or *children* to both people covered.

CIVIL PARTNERSHIP

This applies to same sex *marriages* only, registered in terms of the Civil *Marriages* Act 2004. For a *single life plan*, a partnership between the *person covered* and another person, registered under the *Civil Partnership* Act 2004, excluding a second or subsequent registration of the same two people.

For a *joint life plan*, a partnership between the two people covered, registered under the *Civil Partnership* Act 2004, excluding a second or subsequent registration of the same two people.

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 10% 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 period during which an insured person must be ill or disabled before *we* will pay any *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 *work tasks* and *activities of daily living* (sometimes *we* refer to these as *tasks designed to assess whether you can look after yourself ever again). 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 Optional Serious Illness Cover for *Children*, Disability Cover or Income Protection Cover or Family Income Cover, *you* can also choose for any of these covers to increase in this way.

INSURABLE INTEREST

The following conditions must be satisfied for an *insurable interest* to exist:

- The person taking out the *plan* must stand to be financially worse off if the life assured dies or becomes seriously ill (to a degree capable of valuation); and
- There must be a *legally recognised relationship* between the person taking out the *plan* and the life assured.

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

A cover where the payment is made when the first of the *persons covered* dies or is diagnosed with a *terminal illness*.

JOINT LIFE SECOND DEATH

A cover where the payment is made when the last of the *persons covered* dies or is diagnosed with a *terminal illness*.

LEGALLY RECOGNISED RELATIONSHIP

A *legally recognised relationship* includes:

- An individual has an unlimited *insurable interest* in their own life;
- Legally married couples, or registered civil partners, have unlimited *insurable interest* in each other's lives;
- Employee/employer relationship provided there would be detrimental financial impact to an employer in the event that the employee dies or becomes seriously ill;
- A partner, of a partnership, has *insurable interest* in the life of a co-partner;
- Trustees accountable to pay the inheritance tax on the death of a beneficiary have an *insurable interest* in that beneficiary; and
- Creditor on the life of a debtor, however, only up to the amount of the debt.

LEVEL ACCOUNT

A *plan account* that stays the same unless *you* make a successful claim or change a cover. If *you* have Optional Serious Illness Cover for *Children*, Disability Cover or Income Protection Cover, *you* can also choose one or more 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.

LONG TERM INTEREST RATE

The 20 year rate from the Bank of England's *UK* government liability nominal spot rate curve. This is the rate which is used to determine annual premium changes if the Interest Rate Optimiser option is selected.

MARRIAGE

For a *single life plan*, the *marriage* of the *person covered*, excluding re-*marriage* to a former spouse.

For a *joint life plan*, the *marriage* of the two people covered to each other, excluding their re-*marriage*.

MAXIMUM MONTHLY BENEFIT AMOUNT

- Income Protection Cover
- Income Protection Cover and Category C Disability Cover combined

The actual amount depends on whether *you* have Short Term or 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
- 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 and availability.

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 life with no prospect of improvement, irrespective of when the cover ends or the insured person expects 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.

PERSON COVERED

The *first person covered* or the *second person covered* as appropriate.

PLAN

The VitalityLife *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 or Serious Illness Cover. 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 fee which *you* may be charged for *Vitality Plus*, Vitality Optimiser or Wellness Optimiser in accordance with the separate Vitality terms and conditions for the healthy living part of *your plan*.

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 one month (only for Optional Serious Illness Cover for *Children*, Core Serious Illness Cover for *Children*, Family Income Cover (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*, Core Serious Illness Cover for *Children*, Family Income Cover (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:

- The last 12 months' payslips or the last P60 certificate.
- 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.
- 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*

PROMOTION OR CHANGE IN JOB LEADING TO A SALARY INCREASE

An increase in basic salary as a direct result of one of these single events:

- A promotion
- The award of a recognised professional qualification
- A change of both *employment* and employer

RESIDENT OF THE UNITED KINGDOM

A person who legally lives in the *United Kingdom* for at least 183 days in any 365 day period.

RESIDUAL DEFICIT

Persisting loss or incapacity that is expected to last throughout *your* life.

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.

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
- Paying Class 2 National Insurance contributions
- Assessable for income tax under Schedule D Case I or II

SERIOUS ILLNESS

An illness or condition that:

- Is defined in Appendix 1
- 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.

SUICIDE

An event where, in *our* reasonable opinion, the life insured took their own life voluntarily and intentionally or through intentional self-inflicted injury.

SURVIVAL PERIOD

The period after an insured event that the insured person has to survive before a claim becomes valid.

TASKS DESIGNED TO ASSESS WHETHER YOU CAN LOOK AFTER YOURSELF EVER AGAIN

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 of daily living*.

TERMINAL ILLNESS - WHERE DEATH IS EXPECTED WITHIN 12 MONTHS

A definite diagnosis by the attending Consultant of an illness that satisfies both of the following:

- The illness either has no known cure or has progressed to the point where it cannot be cured;
- In the opinion of the attending Consultant, the illness is expected to lead to death within 12 months.

UNDERWRITE/UNDERWRITING/ UNDERWRITTEN

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
- 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 lifechanging event

UK UNIVERSITY

Any tertiary education institution which offers a recognised *UK* qualification that meets the criteria listed in provision C7.2.

VITALITY BENEFITS

Vitality Benefits are the additional *benefits* provided to *you* under the *Vitality Programme*. They are either *Vitality Plus* or *Vitality Select* and are automatically included if *you* have Vitality Optimiser or Wellness Optimiser.

VITALITY SELECT

Vitality Select provides the opportunity to earn additional points and a number of rewards when *you* look after *your* health. *Vitality Select* is provided by Vitality Corporate Services Limited and is separate from this *plan* and has its own terms and conditions.

VITALITY PLUS

Vitality Plus provides the opportunity to earn additional points and rewards when *you* look after *your* health. *Vitality Plus* is provided by Vitality Corporate Services Limited and is separate from this *plan* and has its own terms and conditions.

VITALITY PROGRAMME

The discounts and rewards available to all adults on the *plan*. These are provided by Vitality Corporate Services Limited. Please refer to the separate terms and conditions for more information.

VITALITY STATUS

Your Vitality Status is a measure of how much *you've* done to look after *your* health. There are four statuses: Bronze, Silver, Gold and Platinum. *We* work out *your Vitality Status* using the activities *you've* recorded between each *plan anniversary* - the harder *you* work, the higher *your* status.

WE/US/OUR

Vitality Life Limited.

WELLNESS STATUS

Your Wellness Status is a measure of *your* current health. There are three statuses: Everyday, Healthy and Select. *We* work out *your Wellness Status* at *plan anniversary* using the valid results of the health checks *you* have recorded between each *plan anniversary* - the healthier *your* results, the higher *your* status.

WHOLE OF LIFE

The term of a cover that lasts from the cover's *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*.

WORK TASKS

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.

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.

APPENDIX 1

ILLNESSES AND CONDITIONS – DEFINITIONS FOR SERIOUS ILLNESS COVER (SEE PROVISION B2).

This *plan* follows the Guide to Minimum Standards for Critical Illness Cover (2018). 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.

For example 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 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.

1.A CANCER CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY

1 DEFINITIONS

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 7th edition of the International Union against Cancer (pub.Wiley-Liss). For the above definition the following are not covered:

- Stage II non-melanoma skin cancer

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.

Borderline Ovarian Cancer

A diagnosis of an ovarian tumour of borderline malignancy or low malignant potential which has been positively diagnosed with histological confirmation, resulting in surgical removal of an ovary.

For the above definition, the loss of an ovary due to a cyst is excluded.

Cancer – *excluding less advanced cases*

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, sarcoma, Merkel Cell Carcinoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

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 borderline malignancy
  - Having low malignant potential
  - All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least TNM classification T2N0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A
- Any skin cancer (including cutaneous lymphoma) other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin)

Carcinoma in-situ

Any *pre-malignant*, *non-invasive* cell growth positively diagnosed and histologically confirmed as carcinoma in-situ.

For the above definition, the following are not covered:

- Any dysplasia, hyperplasia, metaplasia, intraepithelial neoplasia or low grade squamous intraepithelial lesions not histologically classified as carcinoma in situ
- Polycystic dysplasia or disease
- Polyps at any site not histologically classified as carcinoma in situ
- *Non-invasive* papillary bladder carcinoma, TA bladder carcinoma
- Basal cell and squamous cell carcinoma of the skin

Carcinoma in-situ - treated with surgery to remove the tumour

Diagnosis of Carcinoma in-situ, Gastrointestinal Stromal Tumour or Neuroendocrine Tumour with histological confirmation and characterised by the uncontrolled growth of malignant cells that are confined to the epithelial linings of organs and that has been treated by surgery to remove the tumour.

For the above definition, the following are not covered:

- Any dysplasia, hyperplasia, metaplasia, intraepithelial neoplasia or low grade squamous intraepithelial lesions not histologically classified as carcinoma in situ
- Polycystic dysplasia or disease
- Polyps at any site not histologically classified as carcinoma in situ
- For cervical carcinoma in situ - loop excision, laser surgery, conisation and cryosurgery are not covered
- For carcinoma in situ of the colon or rectum – local excision and polypectomy are not covered
- *Non-invasive* papillary bladder carcinoma, TA bladder carcinoma
- Basal cell and squamous cell carcinoma of the skin
- Tumours treated with only radiotherapy, laser therapy, cryotherapy or diathermy treatment.
- Procedures that are solely for diagnostic purposes

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 with surgery to remove the tumour.

For the above definition the following are excluded:

- Barrett's Oesophagus

Desmoid-type fibromatosis – with specified treatment

A positive diagnosis with histological confirmation of non-malignant aggressive fibromatosis by a hospital consultant resulting in either:

- Surgical removal;
- Radiotherapy; or
- Chemotherapy.

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 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 Carcinoma in-situ.

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.

Moderately Severe Aplastic Anaemia

There must be bone marrow cellularity less than 30% plus 2 of the following present for a minimum of six months:

- Neutrophils less than 1 x 109/L
- Platelets less than 50 x 109/L
- Reticulocytes less than 20 x 109/L

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.

Non-Melanoma Skin Cancer of specified severity

The presence of one or more of any of the following malignant skin lesions:

- Basal cell carcinoma as determined by histological examination that is greater than 5cm in diameter requiring either Mohs' micrographic surgery or standard excision
- Squamous cell carcinoma as determined by histological examination that is greater than 2cm in diameter
- Non-melanoma skin cancer that is larger than 2 centimetres (cm) across and has at least one of the following features:
  - tumour thickness of at least 4 millimetres (mm);
  - invasion into subcutaneous tissue (Clark level V);
  - invasion into nerves in the skin (perineural invasion);
  - poorly differentiated or undifferentiated (cells are very abnormal as demonstrated when seen under a microscope); or
  - has recurred at the site of previous treatment.

For the above definition, the following are not covered:

- Gorlin's Syndrome
- Skin Cancers secondary to Xeroderma Pigmentosa
- Skin Cancers secondary to Albinism
- Bowen's Disease

Severe Aplastic Anaemia

There must be bone marrow cellularity less than 25% plus two of the following present for a minimum of three months:

- Neutrophils less than 0.5 x 109/L
- Platelets less than 20 x 109/L
- Reticulocytes less than 20 x 109/L

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 7th 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:

- Acute Lymphoblastic Leukaemia
- Acute Myeloid Leukaemia
- Advanced cancer classified as a TNM Group Stage III tumour or above
- Advanced Chronic Lymphocytic Leukaemia classified as Binet Stage C
- Advanced Hodgkin's Disease classified as Ann-Arbor Stage III or above
- Advanced Non-Hodgkin's Lymphoma classified Ann-Arbor Stage III or above
- Chronic Myeloid Leukaemia
- Multiple Myeloma
- Severe 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
- Myelodysplasia classified as Intermediate 1 under the International Prognostic Scoring System

Severity Level D:

- Cancer - excluding less advanced cases

- Carcinoma in-situ of the Oesophagus requiring surgery
- Low-Grade Prostate Cancer
- Mastectomy for Carcinoma in-situ of the Breast
- Moderately Severe Aplastic Anaemia

Severity Level E:

- Borderline Ovarian Cancer
- Carcinoma in-situ – treated with surgery to remove the tumour
- Desmoid-type fibromatosis – with specified treatment
- Lumpectomy for Carcinoma in-situ of the Breast
- Myelodysplasia classified as Low risk on the International Prognostic Scoring System

Severity Level G:

- Carcinoma in-situ
- Non-Melanoma Skin Cancer of specified severity

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, histological evidence 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 as covered in this document and *your plan schedule*)
- Cervical, vaginal, vulval or prostatic intraepithelial neoplasia (dysplasia) with histology showing CIN-1, CIN-2, VAIN-1, VAIN-2, VIN-1, VIN-2, PIN-1 or PIN-2
- 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 as covered in this document and *your plan schedule*
- 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 45% 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, or inclusion on the NHS waiting list for, 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, or inclusion on the NHS waiting list for, 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 45% 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 Angioplasty – with specified treatment

Percutaneous coronary intervention (PCI) to correct narrowing or blockages of the left main stem artery, or two or more main coronary arteries. Multiple vessels must be treated at the same time or as part of a planned stage procedure within 60 days of the first PCI.

The main coronary arteries for this purpose are defined as right coronary artery, left anterior descending artery, circumflex artery, or their branches.

PCI is defined as any therapeutic intra-arterial catheter procedure including balloon angioplasty and/or stenting.

The following are not covered:

- Diagnostic angioplasty
- Two angioplasty procedures to a single main artery or branches of the same artery.

Coronary Artery By-pass Grafts

The undergoing of, or inclusion on the NHS waiting list for, 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

The undergoing of, or inclusion on the NHS waiting list for, 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:

- Definite Diagnosis of an acute Myocardial Infarction by a Consultant Cardiologist, which is supported by current medical reports, tests and investigations, as defined by the recognised international standard* prevailing at the time of claim.

For the above definition, the following are not covered:

- Other acute coronary syndromes
- Angina without myocardial infarction
- Myocardial Infarctions that meet the international standard that occurred before cover commenced

*(International standard defined by the European Society of Cardiology or the universal standard definition of Myocardial Infarction.)

Heart Valve Replacement or Repair

The undergoing of, or inclusion on the NHS waiting list for, 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 45% 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) 1 above for a claim to be considered.

Hypertrophic Cardiomyopathy - of specified severity

A disease of the heart muscle which results in thickening and enlargement of the interventricular septum or any myocardial segment. There must be a maximal LV wall thickness of at least 15mm in any myocardial segment confirmed via cardiac imaging and the diagnosis of hypertrophic cardiomyopathy must be confirmed by a consultant cardiologist.

For the above definition the following are not covered:

- Cardiomyopathy secondary to *alcohol or drug abuse*

Iliac Artery Aneurysm Repair

The undergoing of, or inclusion on the NHS waiting list for, 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, or inclusion on the NHS waiting list for, 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 thorascope or mini thoracotomy.

Pericardectomy

The undergoing of, or inclusion on the NHS waiting list for, 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 undergoing of, or inclusion on the NHS waiting list for, the *permanent* insertion of an automatic implantable defibrillator after the occurrence of ventricular tachycardia or ventricular fibrillation.

Permanent Defibrillator Insertion due to Cardiac Arrest

The *permanent* insertion of an automatic implantable defibrillator as a result of a cardiac arrest.

Permanent Pacemaker Insertion

The undergoing of, or inclusion on the NHS waiting list for, 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

A definite diagnosis of peripheral vascular disease by a consultant cardiologist or vascular surgeon with objective evidence from imaging of obstruction in the arteries requiring, or being included on the NHS waiting list for, bypass graft surgery to an artery of the legs.

The following is not covered:

- Angioplasty

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 or bypass of symptomatic stenosis of the carotid artery.

For the above definition the following are excluded:

- Surgery using intravascular techniques

Surgical repair of an Atrial or Ventricular Septal Defect

The undergoing of, or inclusion on the NHS waiting list for, the surgical closure of a defect in the interatrial or interventricular septum. This can be performed through a thoracotomy, or by using endovascular techniques.

Surgical repair of a Structural Abnormality of the Heart

The undergoing of, or inclusion on the NHS waiting list for, surgery requiring median sternotomy (surgery to divide the breastbone)

on the advice of a Consultant Cardiologist to repair a structural abnormality 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 39% or less whilst on *optimal therapy**
- Heart attack resulting in a *permanent* ejection fraction of 39% or less whilst on *optimal therapy**
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of greater than 25 mm
- Any other cardiac condition resulting in a *permanent* ejection fraction of 39% 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 40% and 45% whilst on *optimal therapy**
- Heart attack resulting in a *permanent* ejection fraction of between 40% and 45% whilst on *optimal therapy**
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of between 15mm and 25mm
- Any other cardiac condition resulting in a *permanent* ejection fraction of between 40% and 45% 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 Abnormality of the Heart
- Heart Valve Replacement or Repair
- Endovascular Repair of an Aortic Aneurysm
- Defibrillator Insertion due to Cardiac Arrest

Severity Level E:

- Coronary Angioplasty – with specified treatment
- Iliac Artery Aneurysm Repair
- Femoral Artery Aneurysm Repair
- Keyhole Coronary Artery Bypass Surgery
- 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
- *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 creatine 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 with evidence of previous or current symptoms (these symptoms do not need to be *permanent*).

For the above definition, the following are not covered:

- Other types of dementia.

Alzheimer's Disease - *resulting in permanent symptoms*

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
- 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.

Bacterial Meningitis - *resulting in permanent symptoms*

Confirmation by a Consultant Physician of a definite diagnosis of Bacterial Meningitis supported by cerebrospinal fluid changes consistent with bacterial meningitis resulting in *permanent neurological deficit with persisting clinical symptoms.* All other forms of meningitis, including viral, are not covered.

Bilateral Hemianopia

Permanent and *irreversible* loss of vision in one half of the visual field of both eyes.

Brain and Spinal tumours

A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull or spinal cord.

For the above definition, the following are not covered:

- Tumours in the pituitary gland
- Tumours originating from bone tissue
- Angioma and cholesteatoma

Brain and Spinal tumours – of specified severity

A non-malignant tumour or cyst originating from the brain, cranial nerves, meninges within the skull or spinal cord resulting in *permanent neurological deficit with persisting clinical symptoms*, or the undergoing of, or inclusion on the NHS waiting list for, surgical removal.

For the above definition, the following are not covered:

- Tumours in the pituitary gland
- Tumours originating from bone tissue
- Angioma and cholesteatoma

Brain Injury due to anoxia or hypoxia

Death of brain tissue due to reduced oxygen supply (anoxia or hypoxia) resulting in *permanent neurological deficit with persisting clinical symptoms.*

Coma

A state of unconsciousness with no reaction to external stimuli or internal needs which requires the use of life support systems

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

The undergoing of, or inclusion on the NHS waiting list for, 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 with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

This must have been reported the National CJD Monitoring Unit as a confirmed case.

Creutzfeldt-Jakob Disease - *resulting in permanent symptoms*

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
- Perceive, understand, express and give effect to ideas

Dementia

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

Dementia - *resulting in permanent symptoms*

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
- Perceive, understand, express and give effect to ideas

Devic's Disease

A definite diagnosis of Devic's disease by a Consultant Neurologist resulting in current symptoms.

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 with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

Encephalitis – *resulting in permanent symptoms*

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

The undergoing of, or inclusion on the NHS waiting list for, 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 at least 6 months, which is supported by appropriate neurological evidence.

Guillain-Barré Syndrome – of specified severity

A definite diagnosis of Guillain-Barré Syndrome by a Consultant Neurologist, confirmed by electromyography and lumbar puncture. There must be evidence of continual and *permanent* weakness or numbness being present for a minimum period at least 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 one of the following motor neurone diseases by a Consultant Neurologist:

- Amyotrophic lateral sclerosis (ALS)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)
- Kennedy's disease, also known as spinal and bulbar muscular atrophy (SBMA)
- Spinal muscular atrophy (SMA)

There must also be evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

Multiple Sclerosis

A definite diagnosis of multiple sclerosis by a Consultant Neurologist with evidence of previous or current symptoms (even if these are not *permanent*).

Muscular Dystrophy

The definite diagnosis of Muscular Dystrophy by a Consultant Neurologist which must be supported by typical changes on muscle biopsy.

Myasthenia Gravis

A definite diagnosis of myasthenia gravis by a consultant neurologist. There must have been clinical impairment of motor function in parts of the body other than the eye muscles caused by myasthenia gravis.

For the above definition, the following is not covered:

- myasthenia gravis limited to eye muscles only.

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) 1, *benefit*s 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 a limb

Total and *irreversible* loss of muscle function to the whole of any limb.

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 with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

For the above definition, the following is not covered:

- Parkinsonian syndromes/ Parkinsonism.

Parkinson's Disease – *resulting in permanent symptoms*

A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be *permanent* clinical impairment of motor function with associated tremor and muscle rigidity.

For the above definition, the following is not covered:

- Parkinsonian syndromes/ Parkinsonism.

Parkinson's plus syndromes

A definite diagnosis of one of the following Parkinson-plus syndromes by a consultant neurologist:

- Multiple system atrophy
- Parkinsonism-Dementia-ALS complex
- Lewy body disease
- Corticobasal degeneration

There must also be *permanent* clinical impairment of at least one of the following:

- Motor function; or
- Eye movement disorder; or
- Postural instability; or
- Dementia.

For the above definition, the following are not covered:

- Other Parkinsonian syndromes
- Parkinsonism.

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
- 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 with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

Progressive Supra-nuclear Palsy – *resulting in permanent symptoms*

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 aneurysm or arteriovenous malformation

The undergoing of surgical resection,

wrapping, clipping or embolisation of a spinal aneurysm or arteriovenous malformation.

Spinal Stroke

Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal column resulting in *permanent neurological deficit with persisting clinical symptoms*.

Stereotactic Brain Surgery

The undergoing of, or inclusion on the NHS waiting list for, the 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 that results in persisting clinical symptoms lasting for at least 24 hours. For the above definition, the following are not covered:

- Transient ischaemic attack
- Death of tissue of the optic nerve or retina / eye stroke

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.

Syringomyelia or syringobulbia

The undergoing of, or inclusion on the NHS waiting list for, surgery to treat a syrinx in the spinal cord or brain stem.

Traumatic Brain Injury - with clinical symptoms

Death of brain tissue due to traumatic injury resulting in clinical symptoms that have persisted for a continuous period of at least two weeks (these symptoms do not need to be *permanent*).For the above definition the following is not covered:

- Traumatic Brain injury secondary to *alcohol or drug abuse*

Traumatic Brain Injury – *resulting in permanent symptoms*

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.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

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 - of specified severity
- Paralysis of a limb

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:

- Alzheimer's disease – *resulting in permanent symptoms**
- Bacterial Meningitis – resulting in *permanent* symptoms
- Brain and Spinal tumours - of specified severity
- Brain Injury due to anoxia or hypoxia
- Coma*
- Craniotomy
- Craniotomy to treat a Cerebral Arteriovenous Malformation
- Creutzfeldt-Jakob Disease – *resulting in permanent symptoms**
- Devic's Disease (Neuromyolitis Optica)
- Dementia – *resulting in permanent symptoms**
- Drainage of Brain Abscess by Craniotomy
- Encephalitis - *resulting in permanent symptoms**
- Functional Surgery for Movement Disorders
- Motor Neurone Disease*
- Multiple Sclerosis*
- Muscular Dystrophy*
- Parkinson's Disease – *resulting in permanent symptoms**
- Parkinson's plus syndromes*
- Progressive Supra-nuclear Palsy – *resulting in permanent symptoms**
- Shunt Insertion for Hydrocephalus (restricted to one payment only)
- Spinal Stroke
- Stroke*
- Syringomyelia or syringobulbia
- Traumatic Brain injury - *resulting in permanent symptoms**

*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:

- Endovascular treatment of a Cerebral Arteriovenous Malformation
- Guillain-Barré Syndrome
- Myasthenia Gravis
- Spinal aneurysm or arteriovenous malformation
- Surgical Repair of Depressed Skull Fracture

Severity Level F:

- Alzheimers Disease
- Bacterial Meningitis
- Brain and Spinal tumours
- Creutzfeldt-Jakob Disease
- Dementia
- Encephalitis

- Parkinsons Disease
- Progressive Supra-nuclear Palsy
- Stereotactic Brain Surgery
- Traumatic Brain Injury - *resulting in clinical symptoms**

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
- Chronic Fatigue Syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free Disease.
- 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

Bowel Ischaemia requiring surgery

Death of intestinal tissue as a result of impaired blood supply caused by one of the following conditions;

- Acute mesenteric ischaemia
- Chronic mesenteric ischaemia
- Ischaemic colitis

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
- 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
- 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 or Ulcerative Colitis

A definite diagnosis of Crohn's Disease or Ulcerative Colitis by a Consultant Gastroenterologist. To meet the definition of moderate, at least one site of deep tissue intestinal tract must be affected by continued or relapsing inflammation, with one or more flare-ups each year.

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
- 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 Gastrointestinal Disease - requiring hospitalisation

Objective evidence of severe gastrointestinal disease with all of the following:

- Disturbance of bowel function at rest with severe persistent pain for a minimum of 3 consecutive months
- Limitation of activity with continued restriction of diet and no response to medical therapy for a minimum of 3 months
- There have been 2 hospital admissions to treat this condition in the 12 months prior to claim

For the above definition, the following are not covered:

- Any hospitalisation for diagnostic purposes
- Any hospitalisation for other conditions
- Any hospitalisation relating to *alcohol or drug abuse*
- Irritable Bowel Syndrome

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,
  - 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-Oesophogeal Fistula

The undergoing of, or inclusion on the NHS waiting list for, 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 Gastrointestinal Disease - requiring hospitalisation
- Severe Inflammatory Crohn's Disease

Severity Level D:

- Bowel Ischaemia requiring surgery
- 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 Tracheo-Oesophageal Fistula
- *Permanent* Rectal Fistula.

- Moderately Severe Inflammatory Crohn's Disease or Ulcerative Colitis

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, sero-negative rheumatoid 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)
- 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 Erythematosis (SLE)

The definite diagnosis of Systemic Lupus Erythematosis (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 Rhematic 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*. Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

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 erythematosis, 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 erythematosis, 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 erythematosis, 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 erythematosis, 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 erythematosis, 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 undergoing of, or inclusion on the NHS waiting list for, 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 m2 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 *permanently* required.

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 overleaf.

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 m2 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 Arterial 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

Chronic hypoxaemia on a *permanent* basis with a concentration of oxygen in the arteries of less than 8 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.

Pulmonary Arterial Hypertension – of specified cause and severity or requiring surgery

A definite diagnosis of one of the following by a consultant cardiologist or consultant respiratory physician:

- Idiopathic pulmonary arterial hypertension

- Chronic thrombo-embolic pulmonary hypertension

With either:

- The measurement reported at the average level measured by cardiac catheterisation at 30mmHG (mm of mercury) or higher at rest. There must also be right ventricular dilation and hypertrophy on echocardiogram with characteristic ECG changes; or
- The undergoing of, or inclusion on the NHS waiting list for, surgery requiring median sternotomy (surgery to divide the breast bone) or thoracotomy on the advice of a consultant cardiologist for the disease of the pulmonary artery to excise and replace the disease pulmonary artery with a graft.

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 undergoing of, or inclusion on the NHS waiting list for, 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 undergoing of, or inclusion on the NHS waiting list for, 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
- Home Oxygen Therapy
- Cor Pulmonale
- Pulmonary Arterial Hypertension – of specified cause and severity or requiring surgery

Severity Level C:

- 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

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 HUMAN IMMUNODEFICIENCY VIRUS (HIV) CATEGORY – MEETING SPECIFIED CRITERIA

1 DEFINITIONS

HIV infection.

Infection by HIV resulting from:

- A blood transfusion given as part of medical treatment
- A physical or sexual assault
- An incident occurring during the course of performing normal duties of *employment*
- An organ transplant

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 one of the countries in the list of *permitted countries*

For the above definition, the following is not covered:

- HIV infection resulting from any other means, including sexual activity or drug abuse

2 SEVERITY LEVELS

Severity Level A:

HIV infection resulting from:

- A blood transfusion given as part of medical treatment
- A physical or sexual assault
- An incident occurring during the course of performing normal duties of *employment*
- An 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.

We will require evidence of a negative HIV test within 5 days of the incident and the subsequent positive HIV 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
- 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.

Intensive care for 10 days continuous duration

Any sickness or injury resulting in the *person covered* requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) or more in an intensive care unit in a *UK* hospital.

For the above definition the following are not covered:

- *Children* under the age of 30 days
- Sickness or injury as a result of drug or alcohol intake or other self-inflicted means

Le Fort III Reconstruction

This is a form of surgical repair of the maxillofacial bones for severe facial trauma.

Less Extensive Skin Burns – covering 15% of the body's surface area

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue covering at least 15% of the body's surface area.

Less Extensive Skin Burns – covering 10% of the body's surface area

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue covering at least 10% of the body's surface area.

Less Extensive Skin Burns – covering 5% of the body's surface area or 10% of the surface area of the face

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue covering at least 5% of the body's surface area or 10% of the surface area of the face.

Face is the surface area of the front of the head from the top of the hairline to the base of the chin and from ear to ear.

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.

Necrotising fasciitis

A definite diagnosis of necrotising fasciitis or gas gangrene by a consultant physician, requiring immediate surgery to remove necrotic tissue and intravenous antibiotic treatment.

Severe Sepsis

A definite diagnosis of severe sepsis by a consultant physician with at least one additional organ dysfunction, requiring admission to either an intensive care (ICU) or a high dependency unit (HDU) for at least 72 continuous hours.

Surgical Re-attachment of an Amputated Limb

Surgery to re-attach a limb following amputation at or above the wrist or ankle joint.

Extensive Skin Burns

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue, covering at least 20% of the body's surface area or 25% of the surface area of the face.

Face is the surface area of the front of the head from the top of the hairline to the base of the chin and from ear to ear.

2 SEVERITY LEVELS

How Is Severity Measured?

Extensive Skin 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:

- Extensive Skin Burns
- Loss of hands or feet

Severity Level B:

- Loss of a single limb
- Less Extensive Skin Burns covering 15% of the body's surface area

Severity Level C:

- Intensive Care of 10 days continuous duration
- Less Extensive Skin Burns covering 10% of the body's surface area

Loss of use of a whole hand

- Loss of a single hand or foot

- Necrotising fasciitis

Severity Level D:

- Surgical Re-attachment of an Amputated Limb

Severity Level E:

- Le Fort III Reconstruction
- Less Extensive Skin Burns covering 5% of the body's surface area or 10% of the surface area of the face
- Severe Sepsis

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.

Corneal Transplant

Replacement of a portion or entire cornea with a healthy cornea as a result of disease, accident or trauma. The surgery must be performed by a consultant ophthalmic surgeon or ophthalmologist.

For the above definition, the following are not covered:

- Any corneal transplant surgery for vision correction in the absence of damage, disease or injury to the cornea.

Central Retinal Occlusion

Death of optic nerve or retinal tissue due to inadequate blood supply or haemorrhage within the central retinal artery or vein, resulting in *permanent* visual impairment of the affected eye.

For the above definition, the following are not covered:

- Branch retinal artery or vein occlusion or haemorrhage

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
- Central Retinal Occlusion
- Tunnel Vision
- Surgical Removal of one Eye

Severity Level F:

- Corneal Transplant
- 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.L 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).

Insulin dependent Diabetes Mellitus (Type I)

Diagnosis of Diabetes Mellitus (Type 1), characterised by absolute insulin deficiency requiring on going treatment with exogenous insulin for survival.

For the above definition, the following are not covered:

- Gestational Diabetes
- Type 2 Diabetes (including Type 2 Diabetes treated with insulin)
- Latent Autoimmune Diabetes of Adulthood

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
- Insulin dependent Diabetes Mellitus (Type 1)
- 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 Non-Insulin dependent Diabetes Mellitus (Sugar Diabetes)
- Any second claim at any time under any of the illnesses listed above in provision 1 l) 1.
- 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, pancreas; or of a lobe of lung or liver from another donor; 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

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

Your plan schedule indicates which of the following definitions apply. Sections a and b do not apply to *children*, instead section c) total *permanent* disability for *children* will apply. Please see below

a) Total permanent disability – *own occupation*

i. Total *permanent* disability – unable before age 70 to do *your own occupation* ever again

Loss of the physical or mental ability through an illness or injury before age 70 to the extent that *you* are unable to do the material and substantial duties of *your own occupation* ever again. The material and substantial duties are those that are normally required for, and/or form a significant and integral part of, the performance of *your own occupation* that cannot reasonably be omitted or modified.

Own occupation means *your* trade, profession or type of work *you* do for profit or pay. It is not a specific job with any particular employer and is

irrespective of location and availability.

The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or *you* expect to retire.

For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

b) Total and Permanent Disability – *permanent* failure of functional activity

i. Total *permanent* disability

Unable, before age 65 to do a specified number of *work tasks* ever again (listed in provision D5.4).

The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or *you* expect to retire.

You must need the help or supervision of another person and be unable to perform the task on *your* own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

ii. Total *permanent* disability – unable to do a specified number of *tasks designed to assess whether you can look after yourself ever again*

Loss of the physical ability through an illness or injury to do a specified number of tasks *designed to assess whether you can look after yourself* (listed in provision D5.4) ever again.

The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or *you* expect to retire.

You must need the help or supervision of another person and be unable to perform the task on *your* own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

c) Total permanent disability for children – this section only applies to *children*

The *child you* are claiming for becomes *permanently* disabled through illness or injury to the extent that the *child* will require constant medical attention, and constant supervision by another person.

The disability and requirement for constant supervision must be expected to last throughout the *child*'s life.

All diagnoses must:

- be made by a consultant *employed* at a hospital within the *United Kingdom*, who is a specialist in an area of medicine appropriate to the cause of the claim,
- be definite and final, and
- be confirmed by *our* chief medical officer.

2 SEVERITY LEVELS

How is severity measured for total permanent disability – unable before age 65, to do a specified number of work tasks ever again or total permanent disability – unable to do a specified number of tasks designed

to assess whether you can look after yourself ever again?

The severity of a condition claimed under either of these *benefits* will be determined by the *permanent* inability to perform a number of tasks ever again. These tasks are listed in provision D5.4.

The inability to perform a particular task or number of tasks has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

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 *permanent* disability – unable before age 70 to do *your own occupation* ever again
- Total *permanent* disability – unable, before age 65, to do at least 4 *work tasks* ever again
- Total *permanent* disability – unable to do at least four *tasks designed to assess whether you can look after yourself ever again*
- Total *permanent* disability for *children*

Severity Level C:

- Total ***permanent*** disability – unable, before age 65, to do at least two ***work tasks*** ever again
- Total *permanent* disability – unable to do at least two *tasks designed to assess whether you can look after yourself ever again*

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*

APPENDIX 2

ILLNESSES AND CONDITIONS IMPACTED BY SERIOUS ILLNESS COVER BOOSTER

If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster, the lump sum that *we* pay *you* in the event of a claim for certain *serious illness* conditions may be increased. This Appendix lists the conditions to which Serious Illness Cover Booster applies (see Provision B2.3). For details of the definitions for these conditions please refer to Appendix 1.

APPENDIX 2.1

If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster then in the event of a claim for a Serious Illness Cover condition listed below *we* will increase the lump sum *we* pay *you* to 100% of *your* serious illness cover.

CONDITION

Cancer

- Advanced Hodgkin's disease, classified as Ann-Arbor Stage II
- Advanced Non-Hodgkin's Lymphoma, classified as Ann-Arbor Stage II
- Advanced Cancer classified as a TNM group stage II tumour
- Cancer
- Myelodysplasia, classified as Intermediate 1 under the International Prognostic Scoring System

Connective Tissue Disease

For the following conditions which result in the *permanent* inability to perform at least 3 out of 6 *functional activity tests*:

- Giant Cell Arteritis
- Polyarteritis nodosa
- Polymyositis
- Rheumatoid Arhthritis
- Systemic Lupus Erythematosis
- Systemic Sclerosis (Scleroderma)
- Wegener's Granulomatosis

Heart and artery

- Any other cardiac condition resulting in *permanent* ejection fraction of between 40% and 45% whilst on *optimal therapy*
- Aorta graft surgery
- Cardiomyopathy resulting in *permanent* ejection fraction of between 40% and 45% whilst on *optimal therapy*
- By-pass graft surgery to three or more coronary arteries
- Coronary artery by-pass grafts
- Heart Attack
- Heart Attack resulting in *permanent* ejection fraction of between 40% and 45% whilst on *optimal therapy*
- Heart valve replacement or repair
- Hypertrophic Cardiomyopathy - resulting in maximal LV wall thickness between 15mm and 25mm
- *Permanent* Defibrillator Insertion due to Cardiac Arrest
- Surgical repair of a structural abnormality of the heart

Musculoskeletal trauma

- Intensive Care for 10 days' continuous duration
- Less Extensive Skin Burns covering 15% of the body's surface area
- Loss of a single hand or foot
- Loss of a single limb
- Loss of use of a whole hand

Respiratory

- Stage IV Chronic obstructive pulmonary disease
- Fibrotic lung disease with transfer factor (or diffusing capacity) for carbon monoxide of between 35% and 39% of predicted

Stroke and nervous systems

- Any neurological disease causing *permanent* and *irreversible* inability to perform 3 out of 6 *functional activity tests*
- Alzheimer's disease - resulting in *permanent* symptoms
- Bacterial Meningitis – resulting in *permanent* symptoms
- Brain and Spinal tumours – of specified severity
- Bilateral hemianopia
- Coma
- Creutzfeldt-Jakob disease - resulting in *permanent* symptoms
- Dementia - resulting in *permanent* symptoms
- Devic's Disease (Neuromyolitis Optica)
- Encephalitis - resulting in *permanent* symptoms
- Guillain-Barré Syndrome – of specified severity Rankin Scale
- Motor neurone disease
- Multiple Sclerosis
- Muscular Dystrophy
- Paralysis of a limb
- Parkinsons Disease - resulting in *permanent* symptoms
- Progressive Supra-nuclear palsy - resulting in *permanent* symptoms
- Stroke
- Stroke with a *residual deficit* measuring at least 3 on the Modified Rankin Scale
- Stroke with a *residual deficit* measuring at least 2 on the Modified Rankin Scale
- Surgery for drug resistant epilepsy
- Traumatic Brain injury - resulting in *permanent* symptoms

Urogenital and kidney

- Severe chronic renal impairment

APPENDIX 2.2

If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster then in the event of a claim for a Serious Illness Cover condition listed below *we* will increase the lump sum *we* pay *you*. The increase in lump sum will depend on *your* age at the time *you* claim and the number of dependent *children* covered under Optional Serious illness cover for *Children* or Education Cover in this *plan*. The way the increase in lump sum is calculated is described in provision B2.3.

CONDITION

Connective Tissue Disease

For the following conditions which result in the *permanent* inability to perform at least 4 out of 6 *functional activity tests*:

- Giant Cell Arteritis
- Polyarteritis nodosa
- Polymyositis
- Rheumatoid Arhthritis
- Systemic Lupus Erythematosis
- Systemic Sclerosis (Scleroderma)
- Wegener's Granulomatosis

Eye

- Blindness
- Severe visual impairment

Gastrointestinal

- *Permanent* faecal incontinence

Musculoskeletal trauma

- Loss of hands or feet
- Extensive Skin Burns

Permanent disability

- Cauda Equina
- Total and *permanent* disability - unable to do at least four tasks designed to assess whether *you* can look after *your*self ever again.
- Total and *permanent* disability - unable before age 65 to do at least four *work tasks* ever again

- Mental and Behavioural disorder - persistent confusional state to age 70

Total and *permanent* disability - unable before age 70 to do *your own occupation* ever again

- Mental and Behavioural disorder - total lack of social interaction to age 70

Stroke and nervous systems

- Any neurological disease causing *permanent* and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Alzheimer's disease causing permanent and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Brain and Spinal tumours causing *permanent* and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Coma causing the inability to perform 4 out of 6 *functional activity tests*
- Creutzfeldt-Jakob disease - causing *permanent* and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Dementia causing *permanent* and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Encephalitis causing permanent and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Loss of manual dexterity
- Loss of muscle power resulting in the inability to grip
- Loss of speech
- Motor Neurone Disease causing permanent and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Multiple Sclerosis causing *permanent* and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Muscular Dystrophy causing *permanent* and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Paralysis of limbs
- Parkinson's Disease causing *permanent* and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Persistent vegetative state
- Progressive Supra-nuclear palsy causing *permanent* and *irreversible* inability to perform 4 out of 6 *functional activity tests*
- Stroke with residual deficit measuring 4 or above on the modified rankin scale
- Traumatic Brain Injury - causing *permanent* and *irreversible* inability to perform 4 out of 6 *functional activity tests*

APPENDIX 3

DISABILITY COVER ILLNESSES AND CONDITIONS.

ILLNESSES AND CONDITIONS – DEFINITIONS FOR DISABILITY COVER (SEE PROVISION C3).

1.A ADVANCED CANCER CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY.

1 DEFINITIONS

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 7th edition of the International Union against Cancer (pub.Wiley-Liss). For the above definition the following are not covered:

- Stage II non-melanoma skin cancer.

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*.

Severe aplastic anaemia

There must be bone marrow cellularity less than 25% plus two of the following present for a minimum of three months:

- Neutrophils less than 0.5 x 109/L
- Platelets less than 20 x 109/L
- Reticulocytes less than 20 x 109/L

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
- Severe Aplastic Anaemia

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 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*

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 45% 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 45% 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 45% 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.

Hypertrophic Cardiomyopathy - of specified severity

A disease of the heart muscle which results in thickening and enlargement of the interventricular septum or any myocardial segment. There must be a maximal LV wall thickness of at least 15mm in any myocardial segment confirmed via cardiac imaging and the diagnosis of hypertrophic cardiomyopathy must be confirmed by a consultant cardiologist.

For the above definition the following are not covered:

- Cardiomyopathy secondary to *alcohol or drug abuse*.

Severe Peripheral Vascular Disease

A definite diagnosis of peripheral vascular disease by a consultant cardiologist or vascular surgeon with objective evidence from imaging of obstruction in the arteries requiring, or being included on the NHS waiting list for, bypass graft surgery to an artery of the legs.

The following is not covered:

- Angioplasty

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 form 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 39% or less whilst on *optimal therapy*
- Heart attack resulting in a *permanent* ejection fraction of 39% or less whilst on *optimal therapy*
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of greater than 25mm
- Any other cardiac condition resulting in a *permanent* ejection fraction of 39% 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 40% and 45% whilst on *optimal therapy*
- Heart attack resulting in a *permanent* ejection fraction of between 40% and 45% whilst on *optimal therapy*
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of between 15mm and 25 mm.
- Any other cardiac condition resulting in a *permanent* ejection fraction of between 40% and 45% 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 C3.1 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*

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 a lobe of 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
- 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 C3.1 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*

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

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
  - 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 C3.1 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*

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 erythematosis, 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)
- 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 Erythematosis (SLE)

The definite diagnosis of Systemic Lupus Erythmatosis (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 Skin Burns – covering 10% of the body's surface area

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue 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
- 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.

Extensive Skin Burns

Deep partial thickness burn that requires a skin graft or burns that involve damage or destruction of the skin to its full depth through to the underlying subcutaneous tissue or deeper underlying tissue, covering at least 20% of the body's surface area or 25% of the surface area of the face.

Face is the surface area of the front of the head from the top of the hairline to the base of the chin and from ear to ear.

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*. Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in provision D5.4.

Extensive Skin 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.

Category Level A:

- Extensive Skin Burns
- 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 Skin Burns – covering 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 C3.1 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*

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
- 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
- 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 a Limb

Total and *irreversible* loss of muscle function to the whole of any limb.

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
- 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 lasting for at least 24 hours*. For the above definition, the following are not covered:

- Transient ischaemic attack
- Death of tissue of the optic nerve or retina / eye stroke

Total Aphasia

The total lack of the ability to speak. The disability must be *permanent* and supported by appropriate neurological evidence.

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*.

Further details of these *functional activity tests*, including which tests

may apply to *you*, are provided in provision D5.4.

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:

- Bilateral hemianopia*
- Dementia
- Loss of eye-hand co-ordination
- Loss of use of a leg
- Loss of use of a whole hand
- Paralysis of a limb
- 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.

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 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*

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 m2 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 *permanently* required.

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 C3.1 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*

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 Arterial 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).

Home Oxygen Therapy

Chronic hypoxaemia on a *permanent* basis with a concentration of oxygen in the arteries of less than 8 kPa. Supplemental oxygen therapy must be used at home for at least 13 hours each day.

Lung Transplant

The undergoing as a recipient of a transplant of lung, a lobe 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.

Pulmonary Arterial Hypertension – of specified cause and severity or requiring surgery

A definite diagnosis of one of the following by a consultant cardiologist or consultant respiratory physician:

- Idiopathic pulmonary arterial hypertension
- Chronic thrombo-embolic pulmonary hypertension

With either:

- The measurement reported at the average level measured by cardiac catheterisation at 30mmHG (mm of mercury) or higher at rest. There must also be right ventricular dilation and hypertrophy on echocardiogram with characteristic ECG changes; or
- The undergoing of, or inclusion on the NHS waiting list for, surgery requiring median sternotomy (surgery to divide the breast bone) or thoracotomy on the advice of a consultant cardiologist for the disease of the pulmonary artery to excise and replace the disease pulmonary artery with a graft.

Removal of Two or more Lobes of the Lungs

The undergoing of, or inclusion on the NHS waiting list for, 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
- Home Oxygen Therapy
- Lung, or Heart and Lung transplant
- Inclusion on an official *UK* waiting list for the transplantation of a lung, or a heart and lung
- Pulmonary Arterial Hypertension – of specified cause and severity or requiring surgery
- 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 C3.1 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 any named condition.
- Any exclusion applied specifically to *your plan*

1.I PERMANENT FAILURE OF FUNCTIONAL ACTIVITY

i) **Total permanent disability –** unable, before age 65, to do a specified number of work tasks ever again

Loss of the physical ability through an illness or injury to do a specified number of *work tasks* (listed in provision D5.4) ever again.

The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or *you* expect to retire.

You must need the help or supervision of another person and be unable to perform the task on *your* own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

ii) **Total permanent disability** – unable to do a specified number of *tasks designed to assess whether you can look after yourself ever again*

Loss of the physical ability through an illness or injury to do a specified number of *tasks designed to assess whether you can look after yourself* (listed in provision D5.4) *ever again*

The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or *you* expect to retire.

You must need the help or supervision of another person and be unable to perform the task on *your* own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

2 SEVERITY LEVELS

How is severity measured for Total permanent Disability – unable, before age 65, to do a specified number of work tasks ever again or total permanent disability – unable to do a specified number of tasks designed to assess whether you can look after yourself ever again?

The severity of a condition claimed under either of these *benefits* will be determined by the *permanent* inability to perform a number of tasks ever again. These tasks are listed in provision D5.4.

The inability to perform a particular task or number of tasks has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *Functional Activity Tests*, including which tests may apply to *you*, are provided in provision D5.4.

Category Level A:

- Total *permanent* disability – unable, before age 65, to do at least 4 *work tasks* ever again
- Total *permanent* disability – unable to do at least four *tasks designed to assess whether you can look after yourself ever again*

Category Level C:

- Total *permanent* disability – unable, before age 65, to do at least 2 *work tasks* ever again
- Total *permanent* disability – unable to do at least 2 *tasks designed to assess whether you can look after yourself ever again*

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C3.1 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*

APPENDIX 4

LIFESTYLECARE COVER DEFINITIONS

1 DEFINITIONS

SEVERITY LEVEL 1

The amount of the claim depends on the severity of the illness *you* suffer. In order to meet the criteria for Severity Level 1, *you* must meet one of the following definitions:

Alzheimer's Disease - resulting in permanent symptoms

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
  - Perceive, understand, express and give effect to ideas

For the above definition, the following are not covered:

- Other types of dementia

Dementia - resulting in permanent symptoms

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
- Perceive, understand, express and give effect to ideas

Parkinson's Disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a Consultant Neurologist. There must be *permanent* clinical impairment of motor function with associated tremor and muscle rigidity. For the above definition, the following is not covered:

- Parkinsonian syndromes/ Parkinsonism

Severity Level 2

In order to meet the criteria for severity Level 2, *you* must meet one of the following three definitions:

i) *Permanent* inability to perform 3 out of 6 *tasks designed to assess whether you can look after yourself ever again*.

There must be *permanent* clinical loss of the ability to perform three or more of the following tasks. To make this assessment *we* will need an *appropriate medical specialist* to confirm that *you* are *permanently* unable to perform these tasks. *You* must need the help or supervision of another person and be unable to perform the task on *your* own even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

Washing – The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.

Getting dressed and undressed – The ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.

Getting between rooms - The ability to get from room to room on a level floor.

Feeding *your*self – The ability to feed *your*self when food has been prepared and made available.

Getting in and out of bed – The ability to get out of bed into an upright chair or wheelchair and back again.

Maintaining personal hygiene – The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.

For the above definitions, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.

ii) 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.

iii) Severe Stroke - resulting in *permanent* symptoms

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in a *permanent* residual neurological deficit measuring 4 or above on the Modified Rankin Scale.

For the above definition, the following are not covered:

- Transient Ischaemic Attack
- Death of tissue of the optic nerve or retina / eye stroke

2 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision 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*
- For conditions affecting the nervous system any loss of neurological function should be compatible with area of damage of the brain involved.

We will use the Modified Rankin Scale (van Swieten et al. 1988) to measure the severity of a Stroke. This is an internationally accepted measure of disability for Stroke, It is scored from 0 to 5 with 5 being the most severe.

The assessment must be supervised by a Consultant Neurologist.

3 SPECIFIC EXCLUSIONS

- Any condition stated in section 1 above where the required *permanence* has not been established before the cover terminates
- 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*

APPENDIX 5

ILLNESSES AND CONDITIONS IMPACTED BY LATER LIFE OPTIONS.

APPENDIX 5.1

1. DEFINITIONS

Advanced Alzheimer's disease

A definite diagnosis of Alzheimer's disease by a consultant neurologist, psychiatrist or geriatrician resulting in *permanent* inability to perform 2 or more Cognitive Tasks. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

For the above definition, the following are not covered:

- Other types of dementia

Advanced Dementia

A definite diagnosis of dementia by a consultant neurologist, psychiatrist or geriatrician resulting in *permanent* inability to perform 2 or more Cognitive Tasks. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

Nursing Home Care (for at least 3 months) – of specified cause

Permanently (full time) residing in a nursing home for at least 3 months or been receiving support from a nurse or carer at home for at least 5 hours a day on for at least 3 months, due to one of the following conditions:

- *Permanent* inability to perform 4 out of 6 *activities of daily living*
- Advanced Alzheimer's Disease with *permanent* inability to perform 4 out 6 Cognitive Tasks
- Advanced Dementia with *permanent* inability to perform 4 out 6 Cognitive Tasks
- Parkinson's disease resulting in the *permanent* inability to perform 4 out of 6 ADLs
- Stroke with a *residual deficit* measuring 4 or above on the Modified Rankin Scale

For the purposes of this definition:

- A nursing home is defined as a residential care facility with registered nursing staff *permanently* on duty
- A carer is defined as a trained care worker, or group of care workers, in order to assist with nursing or care needs
- All nursing staff must be CQC trained (or equivalent)

Parkinson's disease resulting in the permanent inability to perform 2 or more out of 6 ADLs

A definite diagnosis of Parkinson's disease by a Consultant Neurologist resulting in the *permanent* inability to perform 2 or more out 6 ADLs. For the above definition, the following is not covered:

- Parkinsonian syndromes/ Parkinsonism.

Permanent inability to perform activities of daily living (ADL)

The *permanent* loss of physical ability through illness or injury to do a specified number of *tasks designed to assess whether you can look after yourself ever again*

The relevant specialist must reasonable expect that he disability will last throughout life with no prospect of improvement.

You must need the help of supervision of another person and be unable to perform the task on *your* own, even with the use of specialist equipment routinely available to help and having taken any appropriate prescribed medication.

These specified tasks (*we* also refer to these tasks as *activities of daily living*) are:

- Washing – The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Getting dressed and undressed – The ability to put on, take-off, secure and unfasten all garments and, if needed,
  any braces, artificial limbs or other surgical appliances.
- Getting between rooms - The ability to get from room to room on a level floor.
- Feeding *your*self – The ability to feed *your*self when food has been prepared and made available.
- Getting in and out of bed – The ability to get out of bed into an upright chair or wheelchair and back again. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered.
- Maintaining personal hygiene – The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- The above tasks will be assessed through standardised testing in place at the time of
  the claim.

Residential Home Care (for at least 3 months) – of specified cause

Permanently (full time) residing in a residential care home on a *permanent* basis for at least 3 months due to one of the following conditions:

- *Permanent* inability to perform 4 out of 6 *activities of daily living*
- Advanced Alzheimer's Disease with *permanent* inability to perform 4 out 6 Cognitive Tasks
- Advanced Dementia with *permanent* inability to perform 4 out 6 Cognitive Tasks
- Parkinson's disease resulting in the *permanent* inability to perform 4 out of 6 ADLs
- Stroke with a *residual deficit* measuring 4 or above on the Modified Rankin Scale

For the purposes of this definition:-

- A residential care home is defined as a residential care facility with trained care assistants *permanently* on duty
- All residential staff must be CQC trained (or equivalent)

Stroke with a residual deficit measuring 3 or more on the Modified Rankin Scale

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that results in persisting clinical symptoms lasting for at least 24 hours and measuring 3 or more or above on the Modified Rankin Scale.

For the above definition, the following are not covered:

- Transient ischaemic attack
- Death of tissue of the optic nerve or retina / eye stroke

2. SEVERITY LEVELS

How is severity measured?

To assess the severity of Advanced Alzheimer's disease and Advanced Dementia, the following cognitive tasks will be used.

Cognitive Tasks

The *permanent* loss of cognitive ability through illness or injury to do a specified number of *tasks designed to assess whether you can look after yourself ever again*

The relevant specialist must reasonably expect that the disability will last throughout life with no prospect of improvement.

You must need the help of supervision of another person and be unable to perform the task on *your* own and having taken any appropriate prescribed medication.

The specific tasks are:

- Feeding – Demonstrate the cognitive ability to eat regular meals without being prompted
- Washing – Demonstrate the cognitive ability to initiate appropriately without prompting, and sequence washing by any means, with the use of assistive devices where applicable
- Dressing – Demonstrate the cognitive ability to initiate appropriately without prompting, and sequence, putting on and taking off of all necessary garments, with the use of assistive devices where applicable
- Communication – Demonstrate the ability to present rational ideas and to reason clearly
- Orientation - Demonstrate the cognitive ability to recognise people commonly known to *you* or to recognise when and where *you* are in time and location
- Continence - Demonstrate the cognitive ability to recognise, initiate and sequence the task of bowel and bladder functions such that an adequate level of personal hygiene can be maintained

The above cognitive tasks will be assessed through standardised testing in place at the time of the claim.

Severity Level A:

- Nursing Home Care (for at least 3 months) – of specified cause
- Residential Home Care (for at least 3 months) – of specified cause

Severity Level B:

- *Permanent* inability to perform 4 or more *activities of daily living*
- Stroke with a *residual deficit* measuring 4 on the Modified Rankin Scale
- Parkinson's Disease resulting in the *permanent* inability to perform 4 out of 6 ADLs
- Advanced Alzheimer's Disease resulting in the *permanent* inability to perform 4 out of 6 Cognitive Tasks
- Advanced Dementia resulting in the *permanent* inability to perform 4 out of 6 Cognitive Tasks

Severity Level C:

- *Permanent* inability to perform 3 or more *activities of daily living*
- Parkinson's Disease resulting in the *permanent* inability to perform 3 out of 6 ADLs
- Advanced Alzheimer's Disease resulting in the *permanent* inability to perform 3 out of 6 Cognitive Tasks
- Advanced Dementia resulting in the *permanent* inability to perform 3 out of 6 Cognitive Tasks

Severity Level D:

- *Permanent* inability to perform 2 or more *activities of daily living*
- Stroke with a *residual deficit* measuring 3 on the Modified Rankin Scale
- Parkinson's Disease resulting in the *permanent* inability to perform 2 out of 6 ADLs
- Advanced Alzheimer's Disease resulting in the *permanent* inability to perform 2 out of 6 Cognitive Tasks
- Advanced Dementia resulting in the *permanent* inability to perform 2 out of 6 Cognitive Tasks

3. EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1.2 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 claim to be paid, *we* will require that the extent of permanency has been established to *our* satisfaction.

4. SPECIFIC EXCLUSIONS

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the definitions section of this Appendix, 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* during Serious Illness Cover term

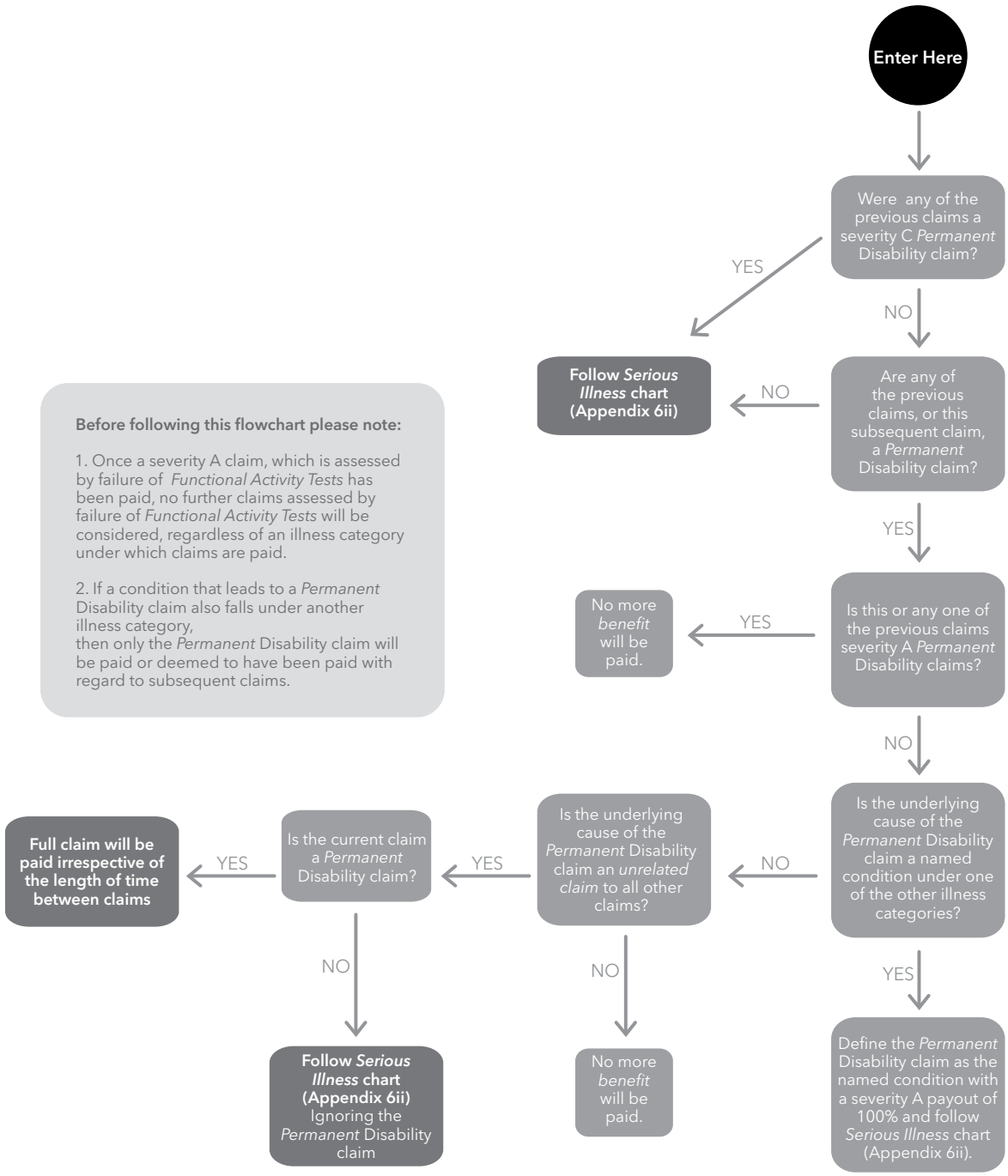
APPENDIX 5.2

If *you* claim for the below conditions under Serious Illness Cover, *you* will not be able to claim for that condition, or any related conditions, under Later Life Options.

SERIOUS ILLNESS COVER CONDITIONS	RELATED CONDITIONS UNDER LATER LIFE OPTIONS
• Total *permanent* disability • Any Neurological Disease causing the *permanent* and *irreversible* inability to perform two or more *functional activity tests* • Any connective tissue disease causing the *permanent* inability to perform one or more *functional activity tests* • A Stroke with a *residual deficit* measuring at least 2 on the Modified Rankin Scale	• Failure of 2 or more *activities of daily living* • Nursing Home Care • Residential Home Care • A Stroke with a *residual deficit* measuring at least 3 on the Modified Rankin Scale • Parkinson's disease resulting in the *permanent* inability to perform 2 or more out of 6 ADLs
• Alzheimer's disease – resulting in *permanent* symptoms • Alzheimer's disease • Dementia – resulting in *permanent* symptoms • Dementia • Persistent Confusional State • Parkinson's Plus syndromes	• Advanced Alzheimer's Disease • Advanced Dementia • Nursing Home Care • Residential Home Care

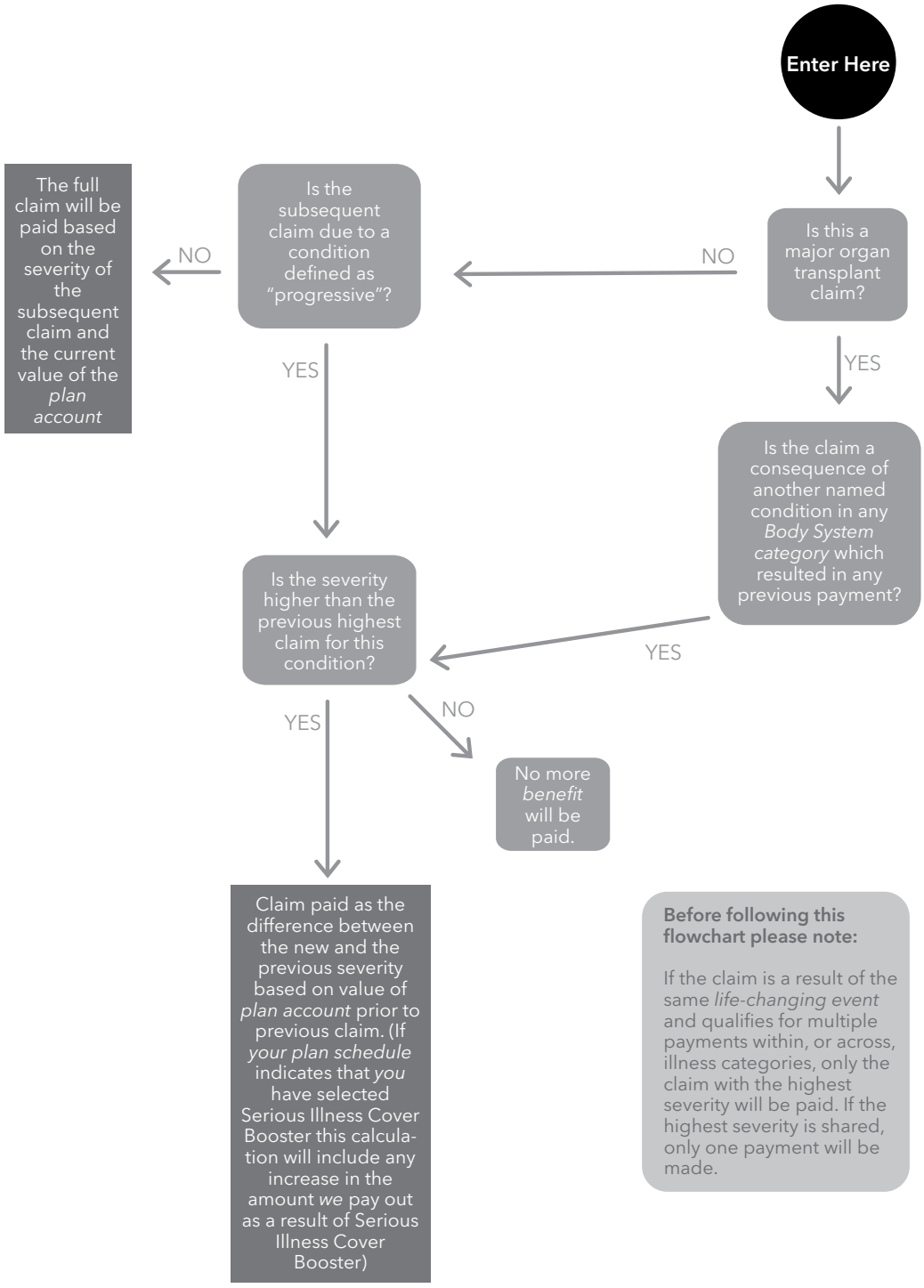
APPENDIX 6
(I) - Subsequent Claims for Serious Illness Cover

ASSESSMENT OF SUBSEQUENT CLAIMS FOR PERMANENT DISABILITY



APPENDIX 6
(II) - Subsequent Claims for Serious Illness Cover

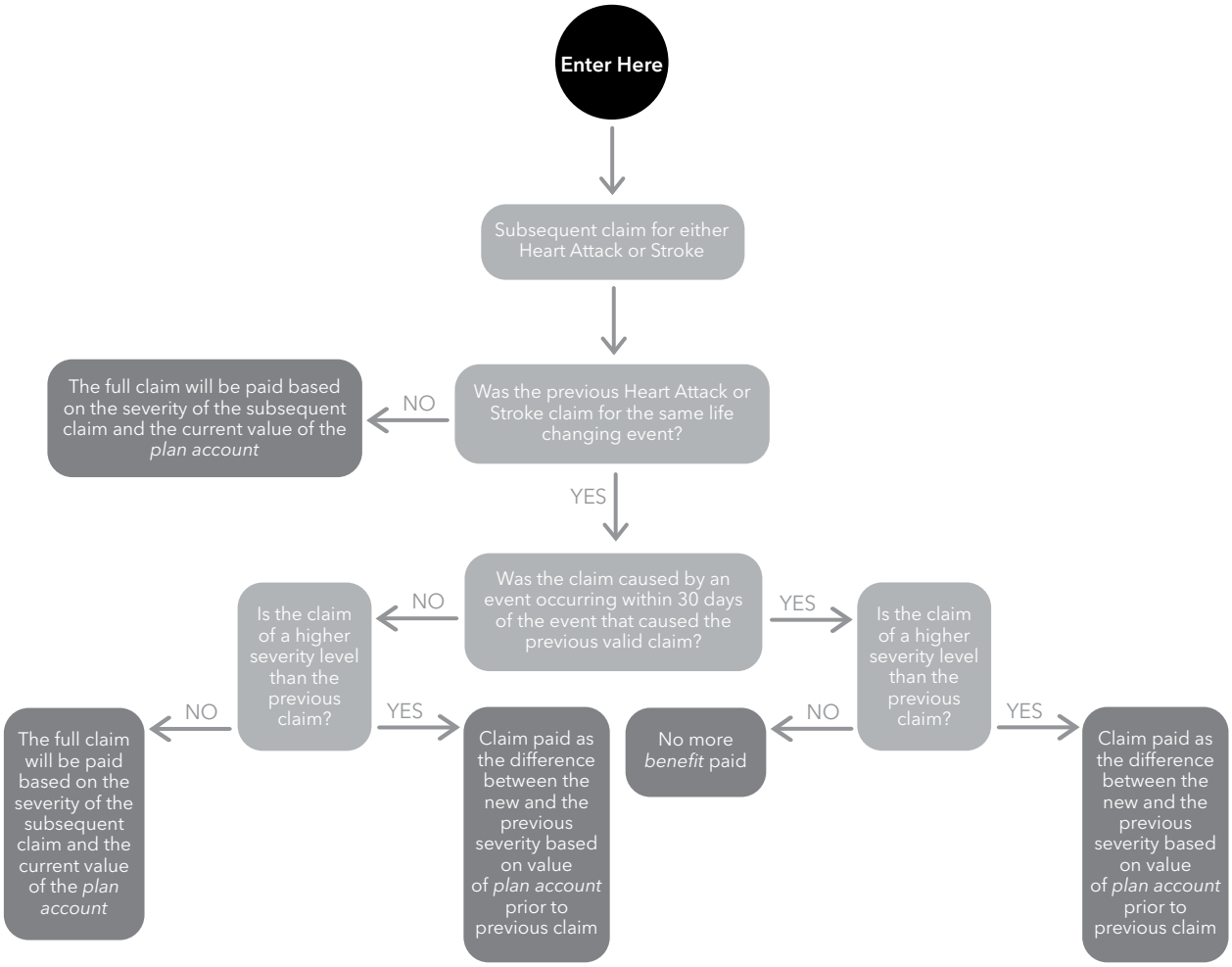
ASSESSMENT OF SUBSEQUENT PROGRESSIVE OR SUBSEQUENT UNRELATED SERIOUS ILLNESS COVER CLAIMS



Note: this does not apply to Heart Attack and Stroke. Please refer to Appendix 6 (iii)

APPENDIX 6
(III) - Subsequent Claims for Serious Illness Cover

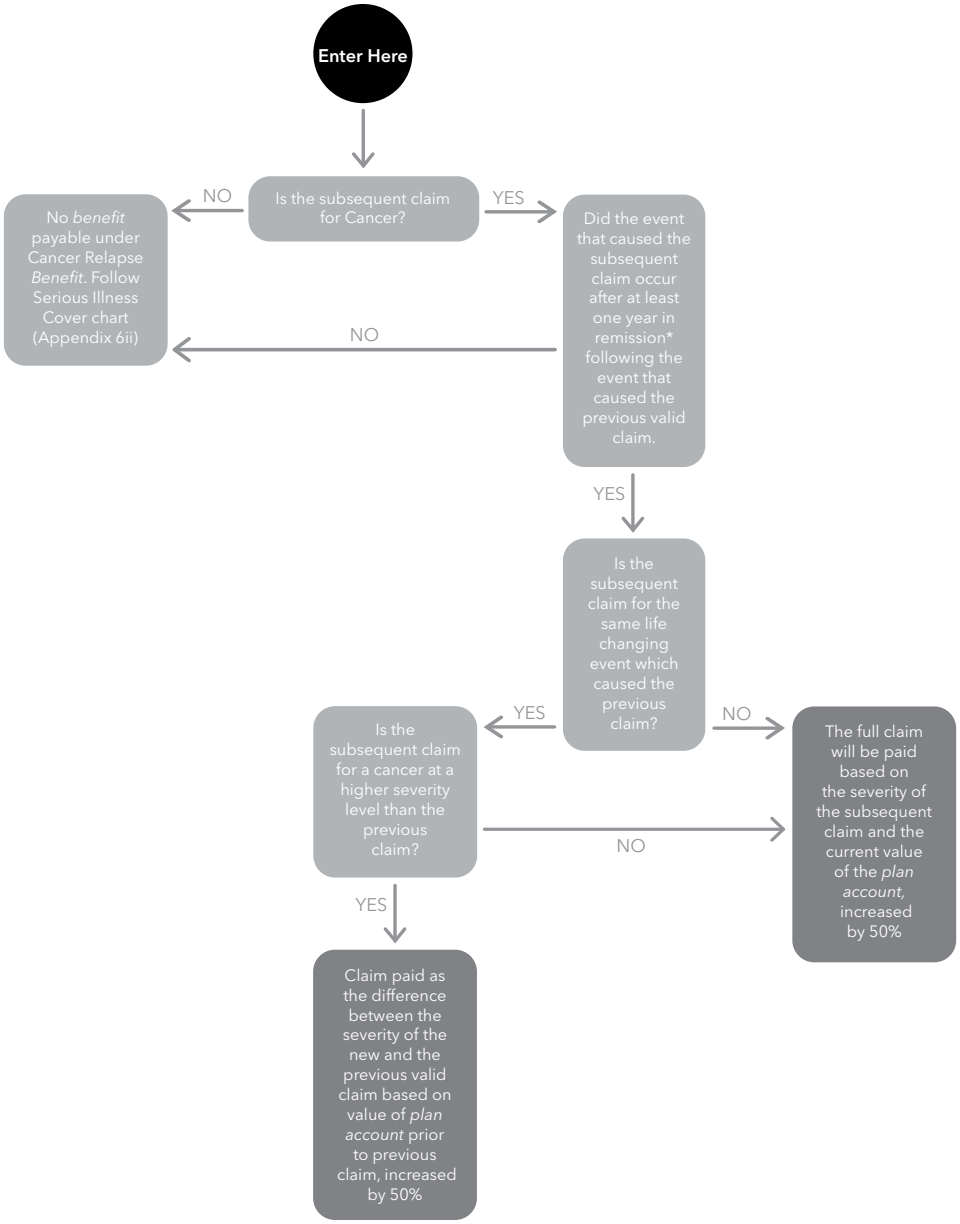
ASSESSMENT OF SUBSEQUENT CLAIMS FOR HEART ATTACK OR STROKE



Note: Heart Attack and Stroke are treated as two different life changing events.

APPENDIX 6
(IV) - Subsequent Claims for Cancer under Cancer Relapse Benefit

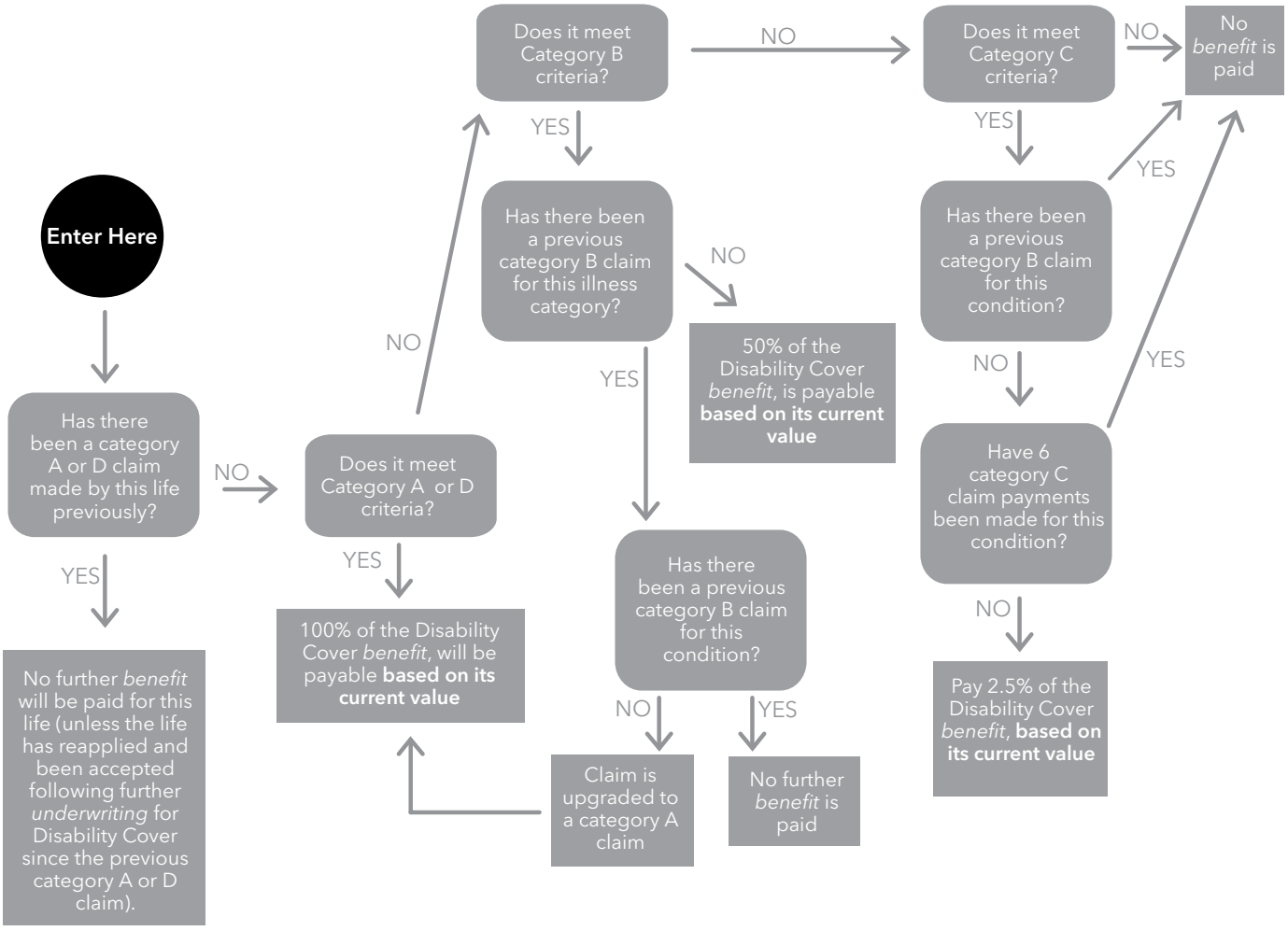
ASSESSMENT OF SUBSEQUENT CLAIMS FOR CANCER UNDER CANCER RELAPSE BENEFIT



*Remission is defined as being cancer free after the completion of chemotherapy, radiotherapy, surgical treatment or biological therapy (if indicated), and confirmed by the subsequent absence of radiological or biochemical (including molecular) evidence of disease. Hormone treatment is not regarded as active treatment for purposed of the remission definition.

APPENDIX 7
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.



Find out more.

For more information please speak to your adviser or visit our website vitality.co.uk/life

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