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VitalityLife Mortgage Plan Provisions.

Health insurance · Life insurance · Investments

MORTGAGE
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 Life Cover which pays a cash lump sum if the *person covered* dies or is diagnosed with a *terminal illness*.

You can choose to add one or more of the following covers to *your plan*:

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

Your plan schedule shows which covers *you* have.

A1. YOUR PLAN ACCOUNT

The amount of Life Cover and Serious Illness Cover Protector *you* have and the amount of *benefit you* could receive are linked to *your plan account*.

When *you* take out a *plan 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.

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*.

You cannot have more Serious Illness Cover Protector than Life Cover. If *you* have both covers, *you* choose the amount of Serious Illness Cover Protector *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 Protector. They can have different amounts of Serious Illness Cover Protector 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 Protector, then the value of *your plan account* may reduce 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* may be lower. Please see provisions C1.4 and C1.5 for more information about how *your plan account* may reduce.

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

Your plan account structure

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

YOUR PLAN ACCOUNT STRUCTURE	WHAT THIS MEANS
LEVEL	The value of the *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 £2,000,000, including any increases as a result of indexation.
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 10% annual equivalent interest rate • The same term as the *plan*.

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 is up to a *fixed date* – this is called a *fixed term*. *Your plan schedule shows* the date on which each of *your* covers *terminates*.

If *your plan* has a *decreasing account* structure (see '*Your plan account* structure' above), Life Cover and Serious Illness Cover Protector must have the same *fixed term*.

B. LIFE COVER

This section provides details of *your* Life Cover which is included in *your plan*.

B1. LIFE COVER

Life Cover pays a lump sum if the *person covered* dies, or is diagnosed with a *terminal illness*. 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	With a *joint life 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 D5.

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 D4.6.

C. OTHER COVERS AND OPTIONS

C1. SERIOUS ILLNESS COVER PROTECTOR

Serious Illness Cover Protector 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.

Our Serious Illness Cover Protector pays out based on a scale, from 15% (Severity E) for the lowest severity level of a condition, to 100% (Severity A) for the highest. So the more severe *your* condition the larger the payment *you*'ll get. For more about severity levels, see 'How much *we* will pay', at provision C1.3.

Serious Illness Cover Protector includes Booster. With Booster, the lump sum *we* pay *you* will be increased if *you* meet certain requirements. For more about Booster, please see provision C1.3.

Serious Illness Cover Protector lasts for a *fixed term*. Serious Illness Cover Protector must have a *date of expiry* on or before the expiry date of *your* Life Cover. If the *plan account* structure is decreasing, Serious Illness Cover Protector must have the same term as *your* Life Cover.

C1.1 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 Protector 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 D4.4.

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.

C1.2 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 C1.1
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 C1.5
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 C1.1
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 Serious Illness Cover Protector expires before the *life-changing event* which leads to *your* claim	*Your plan schedule*

C1.3 How much we will pay

The amount *we* will pay depends on:

- How severe *your* condition is
- The amount of cover *you* have
- Whether *your* claim is for a condition that is included in Booster

The lump sum *we* pay *you* will be a percentage of *your* Serious Illness Cover Protector between 15% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from A to E. If *your* claim is for a condition that is included in Booster, the lump sum *we* pay *you* may be increased. For more about Booster please see below.

SEVERITY LEVEL	WHAT PERCENTAGE OF YOUR SERIOUS ILLNESS COVER PROTECTOR WE WILL PAY
A (most severe)	100%
B	75%
C	50%
D	25%
E (least severe)	*15%*

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

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

Booster

Serious Illness Cover Protector includes Booster. With 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, *we* will increase the lump sum *we* pay *you* to 100% of *your* amount of Serious Illness Cover Protector.

Booster does not apply to claims for Optional Serious Illness Cover for *Children*.

C1.4 How your cover continues after your first claim under Serious Illness Cover Protector

Any payment for a Severity A or a boosted condition under Serious Illness Cover Protector will reduce *your plan account* by the amount *we* have paid *you*.

- If the amount *we* have paid *you* is less than the value of *your plan account*, *your plan* will continue and the amount of Serious Illness Cover Protector remaining will be *your* chosen percentage of the remaining *plan account*.
- If the amount *we* have paid *you* is equal to or greater than the value of *your plan account*, *your plan* will end.

Any payment for other claims under Serious Illness Cover Protector will not reduce *your plan account*.

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

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

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.

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. and the *progressive claim* is also for a condition that is also listed in Appendix 2or 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 and the value of *your plan account* immediately prior to the first claim paid for this *progressive claim* *We* will also pay interest for the period from the original date of claim to the date *we* pay this *progressive claim*.
UNRELATED CLAIMS	
Definition	An *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 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.

C1.5.1 What happens to your plan after you make a subsequent claim

If *your* subsequent claim is for a Severity A or boosted condition under Serious Illness Cover Protector, *we* will reduce the value of *your plan account* by the amount *we* have paid *you*. If this subsequent claim is part of a *progressive claim*, then *we* will reduce the value of *your plan account* by the total claims *we* have paid for the same *life-changing event*.

- If the amount *we* have paid *you* is less than the value of *your plan account*, *your plan* will continue and the amount of Serious Illness Cover Protector remaining will be *your* chosen percentage of the remaining *plan account*.
- If the amount *we* have paid *you* is equal to or greater than the value of *your plan account*, *your plan* will end.

Any payment for other claims under Serious Illness Cover Protector will not reduce *your plan account*.

Other subsequent claims

There are three 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 table on the previous page.

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* claim is for a condition listed in Appendix 2, the amount *we* will pay will include any increase as a result of 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. If *your* new claim is for a condition listed in Appendix 2, the amount *we* will pay will include any increase as a result of 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
- 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 Protector claim if it is for a condition or illness that is not related to the underlying cause of *your permanent* disability claim.

For joint life plans

For payments *we* make under Serious Illness Cover Protector that reduce the value of *your plan account*, this will impact both lives. Each lives remaining Serious Illness Cover Protector *benefit* amount will be their chosen respective percentage of the remaining *plan account*.

If the value of *your plan account* reduces 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 Protector?

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

- £2,000,000; and
- Three times *your* initial amount of Serious Illness Cover Protector – 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.

If *you* reach this maximum *benefit* amount, Serious Illness Cover Protector will be removed from *your plan*.

If *we* do that, *we* will reduce *your* premiums accordingly.

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 Serious Illness Cover Protector, Disability Cover for Business, Serious Illness Cover for Business, 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 £4,000,000.

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.

C1.6 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*.

C1.7 What happens if a single life-changing event causes you to claim for more than one person covered

If a single *life-changing event* causes claims for more than one *person 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.

C1.8 What happens if a single life-changing event means you are eligible for payments under both Serious Illness Cover Protector and Income Protection Cover

If a single *life-changing event* makes *you* eligible for payments under both Serious Illness Cover Protector and Income Protection 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 Protector or Income Protection 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.

C1.9 Family Benefit

If *you* have Serious Illness Cover Protector on *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 provision C1.1.

C1.9.1 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 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 Protector.

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*
- 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.

C1.9.2 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 Protector'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 C1.9.1a 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 Protector.

C1.9.3 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*.

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

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

C2. 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 C2.1.

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

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

C2.1 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 D4.4. *We* use this definition to *assess houseperson* claims. For more about this, see provision C2.6.

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 D4.4.

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 C2.10.

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 the 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.

C2.2 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* policy 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 £3,000 a month.

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 C2.6.

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 PRICE 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 decide whether or not *we* can offer it to *you*, *we* might need to *underwrite your* request.

Indexation increases will not increase *your benefit* amount while *we* are paying a claim under this cover – unless *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 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%.

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.

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 is equal to *your* first full monthly *benefit* payment under Income Protection Cover – up to a maximum of £1,000. The amount is fixed when *you* set up *your plan.*

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*.

C2.3 When we may not pay or reduce the amount we pay you

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

C2.4 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 C2.1.

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 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 claims 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 claims 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.

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 policy that pays a *benefit* to *you* or to a financial institution on *your* behalf

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

Reviewing your claim

We might review *your* claim at any time while *we* are paying *benefits* under

Income Protection Cover, to make sure *you* continue to be eligible for the *benefit*. This means that *you* might periodically need to fill out claim forms.

C2.5 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*.

C2.6 What happens if you are not in employment when you make a claim or you have chosen Houseperson Cover

If you are unemployed or on a career break

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

If *you* claim more than one month after leaving work, *we* will assess *you* as a *houseperson*. *We* may also change the *deferred period* that applies to *your* Income Protection Cover. For more about the *deferred period*, see provision C2.1.

Houseperson claims

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

- A *houseperson*
- A student
- Retired
- Working less than 16 hours a week
- *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 D4.4. *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 C2.2.

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 C2.4
- *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*.

C2.7 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 is as follows:

- 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

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 C2.4
- *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*.

C2.8 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.

C2.9 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 C2.6 and C2.7.

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 C2.4
- *You* death

Waiver of Premium on Incapacity

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

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

C2.10 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 Primary 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.

C2.11 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 C2.4.
- *You* being removed from the *plan*
- The *plan* ceasing
- *Your* death

C3. 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*. 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 *benefits* under this cover to the *planholder*.

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

- *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 C1.
- *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.

C3.3 How much we will pay

How much *we* will pay depends on:

- how severe *your child's* condition is; 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 E:

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

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

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 policy issued by *us* this maximum applies to the total of all payments under these policies and not to each policy separately. This includes where a *joint life plan* has been split.

C3.3 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,* or
- The claim is due to a *pre-existing medical condition*.

C3.4 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.

C3.5 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 C1.5. How *we* calculate the amount *we* will pay is also outlined in provision C1.5 however the calculation will be based on *your* amount of Optional Serious Illness Cover for *Children* rather than the *plan account*. Booster does not apply to Optional Serious Illness Cover for *Children*.

C3.6 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 nights 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.

C4. MORTGAGE FREE COVER

Mortgage Free Cover is temporary Life Cover or Serious Illness Cover Protector or both, that covers *you* before *your plan* starts. It may be relevant to *you* if:

- *Your plan* is to cover a loan to buy or improve *your* home
- *You* do not want *your plan* to start until *you* start paying back *your* loan.

We offer *you* Mortgage Free Cover in this situation because *you* might be legally committed to the loan before *you* start paying it back – for example, if *you* have exchanged contracts to buy a new home.

Mortgage Free Cover only provides Serious Illness Cover Protector for conditions of severity level A or B. For more about how severity levels apply for Serious Illness Cover Protector, see provision C1.3.

We do not charge *you* any premium for Mortgage Free Cover.

C4.1 When you are eligible for Mortgage Free Cover

To be eligible for Mortgage Free Cover, *your plan* application must meet all of the following criteria:

- *You* are using *your plan* to cover a loan arranged through a recognised financial institution
- *You* are using *your* loan to buy or improve *your* home
- *You* are not using *your* loan to pay for a remortgage
- *Your* loan is not covered by another life assurance policy or free cover arrangement like this one
- *You* have applied for Life Cover or Serious Illness Cover Protector or both, and *we* have accepted *your* application and told *you* which of *your* covers the Mortgage Free Cover applies to
- The period from when *you* applied for *your plan* to when *you* are legally committed to a loan for buying or improving *your* home – for example when *you* exchange contracts – is less than four months
- *You* and any other *person covered* must be *you*nger than 50 on the date *we* issue *your acceptance letter*
- *You* have a *single life plan* or a *joint life first death plan*.

C4.2 When Mortgage Free Cover starts

Mortgage Free Cover starts when either of the following events happen:

- *We* issue *your acceptance letter*
- *You* become legally committed to a loan for buying or improving *your* home – for example this might be when *you* exchange contracts

You can only have Mortgage Free Cover in the period immediately before *your plan* starts. *You* cannot have it when *you* are changing *your plan* at a later stage.

C4.3 When we will pay

If *you* need to make a claim under Life Cover while *you* are covered by Mortgage Free Cover, *we* will pay for the same reasons described in provision B1.

If *you* need to make a severity A or B claim under Serious Illness Cover Protector while *you* are covered by Mortgage Free Cover, *we* will pay for the same reasons described in provision C1. *We* will not pay out under Mortgage Free Cover for conditions of lower severity levels.

You must claim within six months of the *life-changing event*.

C4.4 How much we will pay

The amount of Life Cover or Serious Illness Cover Protector *benefit we* pay will be the lowest of:

- The amount of cover that *we* state on *your acceptance letter*
- The amount of *your* mortgage or loan; and
- £300,000

C4.5 When the cover ends

The *date of expiry* of Mortgage Free Cover is when the first of any of these events happen:

- Three months pass since *we* issued *your acceptance letter*

- *Your* mortgage starts
- *Your plan* starts; or
- *You* are no longer legally committed to the loan, for any reason

C5. WAIVER OF PREMIUM ON INCAPACITY

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

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

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

C5.1 When we will waive your premiums

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

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

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 even again*. *We* list these tasks in provision D4.4. *We* use this definition to assess *houseperson* claims, see provision C5.6.

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:

- 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 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:

- 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 *benefits* under Waiver of Premium on Incapacity Cover.

C5.2 How long we will waive your plan premium for

We will start waiving *your plan premium* on the day after *your deferred period* ends. For more about the *deferred period*s, see provision C4.1.

When we stop waiving your plan premium

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

- *You* become able to start work in *your own occupation* again. *We* will base this on *your* ability to work, not the availability of work.
- *You* are no longer suffering any loss of income from *your own occupation*, despite *your* illness or injury
- *You* perform any kind of work for profit or *reward*
- *You* unreasonably refuse to undergo recommended medical treatment or rehabilitation to reduce the effects of *your* illness or injury
- *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

- *You* fail to provide *us* with satisfactory proof that *your* incapacity is ongoing when *we* ask for it. *We* might need this so *we* can confirm that *you* continue to be entitled to the *benefit*.
- *Your* Waiver of Premium on Incapacity reaches its *date of expiry*. *Your plan schedule* shows the *date of expiry* for this cover
- *You* are removed from the *plan*
- The *plan* is cancelled
- *Your* death

C5.3 Which plan premium increases we will waive

While *we* are waiving *your plan premium*, *we* will waive any increases that happen because y*our plan premium* increases as a result of Vitality Optimiser.

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

C5.4 When we will not waive your plan premium

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

C5.5 What happens if you need to claim again

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

- Caused by the same *life-changing event* as the previous claim
- Within three months of the original waiver of premium ending

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

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

If *you* become *unemployed* – or take a *career break* – and claim under Waiver of Premium on Incapacity

Cover within a month of leaving work, *we* will assess *your* claim against *your* previous *own occupation*.

If *you* claim more than one month after leaving work, *we* will assess *you* as a *houseperson*. *We* may also change the *deferred period* that applies to *your* Waiver of Premium on Incapacity Cover. For more about the *deferred period* for Waiver of Premium on Incapacity Cover, see provision C4.1.

Houseperson claims

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

- A *houseperson*
- A student
- Retired
- Working less than 16 hours a week
- *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 D4.4. *You* will not need to give *us* details of *your* earnings when *you* claim.

How long we will pay for

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

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

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

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

- Stop waiving *your plan premium*
- Cancel *your plan*

C5.8 What happens if you change your occupation

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

If *we* would not normally use an *own occupation* definition for that *occupation*, then *we* may use *activities of daily living* to assess *your* claim. For more about *activities of daily living* assessments, see provision D4.4.

C6. GUARANTEED INSURABILITY OPTIONS

Guaranteed Insurability options allow *you* to increase or change the *fixed term* of certain covers if *you* change *your* mortgage, without giving *us* any more information about *your* health. The covers *you* can increase are:

- Life Cover
- Serious Illness Cover Protector
- Income Protection Cover

Guaranteed Insurability options are automatically included in *your plan* as long as:

- *We* accepted *you* and any other *person covered* at standard rates
- *We* have not added any special exclusions to *your plan*

Your plan schedule shows if *your plan* includes Guaranteed Insurability options.

C6.1 When you can use Guaranteed Insurability options

You can use the Guaranteed Insurability option to increase *your* cover if *your* application meets all of the following requirements:

- *You* are using *your plan* to cover a mortgage or mortgages on *your* main residence
- *Your* mortgage has increased, or *you* have taken out a new mortgage
- Any increase in *your* total mortgage payments is solely to pay for a new main residence or to improve *your* existing main residence

You can use the Guaranteed Insurability option to change the *fixed term* of *your* cover if *your* application meets all of the following requirements:

- *You* are using *your plan* to cover a mortgage or mortgages on *your* main residence
- The outstanding term of *your* mortgage has increased, or *you* have taken out a new mortgage and the new mortgage ends after the date that the original mortgage would have ended

We will increase *your* cover as soon as *we* have accepted *your* application.

You can apply to increase *your* cover using Guaranteed Insurability options at any time, as long as *your* application meets all of the following criteria:

- *You* already have the relevant cover
- The change to *your* mortgage has happened in the last three months
- *You* give *us* the evidence *we* ask for to show that the change to *your* mortgage has happened within the last three months
- *You* have not made a successful claim under *your plan*, apart from under Optional Serious Illness Cover for *Children*
- *You* have not reached the *plan anniversary* immediately before *your* 55th birthday
- *Your plan* is not suspended. For more about how this can happen, see provision D1.1
- If *you* apply to increase Income Protection Cover, *you* give *us* proof of *your* earnings

If *you* have a *joint life plan*, and either *person covered* wants to increase their Income Protection Cover, the increase must take place on a *plan anniversary* that occurs at least a year before the Guaranteed Insurability options expire. This means that the increase cannot take place on the *plan anniversary* immediately before that person's 55th birthday.

Splitting a joint life plan into two single life plans upon divorce or dissolution of a civil partnership

You can split a *joint life first death plan* into two separate *single life plans* upon getting divorced or dissolving *your civil partnership*.

You can apply to split *your joint life plan* using the Guaranteed Insurability option at any time, as long as *your* application meets all of the following criteria:

- *You, your* spouse or *your* civil partner must be both persons covered under the original *plan*
- The original *plan* was used for the purpose of protecting a mortgage where:
  - The mortgage has been rearranged to be in the name of just *you*, *your* spouse or *your* civil partner or
  - *You, your* spouse or *your* civil partner have taken out a new mortgage
- The divorce or dissolution of *your civil partnership* has happened in the last three months, and *you* can provide the necessary evidence *we* request
- *Your plan* is not suspended. For more about how this can happen, see provision D1.1
- The two new *plans* must each meet *our* minimum premium requirements

The two new *plans* will be subject to all the provisions that applied to the original *plan* and each *plan* term must be at least as long as *our* minimum term

requirements. Additionally, the amount of cover and term must not be greater than the amount of cover and term *you* had on the original *plan*.

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

- What it would have been if *you* had taken out a *single life plan* when *your plan* started
- Any premium reviews *we* have carried out
- Any changes to *your* premium due to *your Vitality Status* or both *your Vitality Status* and *your Wellness Status*
- Any premium increases as a result of indexation

If either *person covered* wants to add to or increase their cover or increase the *date of expiry* they had under the original *plan*, *we* will need to *underwrite* their request. The *plan premium* will be calculated using premium rates applicable at the time of the request.

We will also reduce any remaining Optional Serious Illness Cover for *Children* so that it does not exceed the total amount in the *plan account*.

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

C6.2 Limits to increases using Guaranteed Insurability options

If *you* use Guaranteed Insurability options to increase a cover that is attached to *your plan account*, the amount of *your plan account* may increase.

- The maximum *you* can increase *your plan account* by, using Guaranteed Insurability options, is £150,000. This maximum applies across the whole life of *your plan*.

The limits to the amount *you* can increase certain covers by are as follows:

	LIFE COVER	INCOME PROTECTION COVER	SERIOUS ILLNESS COVER PROTECTOR
Maximum increase in cover	The amount of the new mortgage or the increase in mortgage	The amount of *your* increased regular mortgage payment, and no more than £8000 a year, and no more than 50% of the initial cover amount.	The amount of the new mortgage or the increase in mortgage

Maximum increase in *fixed term*	The number of additional years for which the mortgage is payable	The number of additional years for which the mortgage is payable	The number of additional years for which the mortgage is payable

The maximum number of times that *you* can increase any of *your* covers using this option over the period of cover is three. The maximum number of times that *you* can change the *fixed term* of *your* covers is once.

If *you* use a Guaranteed Insurability option to split a *joint life first death plan* into two *single life plans* upon divorce or dissolution of a *civil partnership*, the maximum cover for the *second person covered* is £500,000.

C6.3 How using Guaranteed Insurability options affects your plan

If *you* use Guaranteed Insurability options to increase a cover or change a *fixed term*, *we* will increase *your* premium for that cover. *We* will work out the amount of the premium increase using *your* age and the rates that applied at the time of the increase.

If *your plan* includes Waiver of Premium on Incapacity, *we* work out a new premium for this cover. *We* do this using the rates that apply at the time of the increase.

We will apply the same provisions to an increase in cover as those *we* applied when that cover was added to *your plan*.

C6.4 When your Guaranteed Insurability options end

If you make a claim

If *you* make a successful claim under any cover except Optional Serious Illness Cover for *Children*, *we* will cancel *your* Guaranteed Insurability options. If *you* have a *joint life plan*, the other *person covered* can still use their Guaranteed Insurability options, but only for covers that are not attached to the *plan account*.

Date of expiry

Your Guaranteed Insurability options end on the *plan anniversary* immediately before *your* 55th birthday.

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 premiums* either monthly or annually, in advance. *Your* selected payment frequency is shown in *your plan schedule*. If *you* have selected monthly, *your plan premiums* 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 the Waiver of Premium on Incapacity depends on the premiums *you* pay for the other covers *you* have in *your plan*.

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 premiums*. If *your plan premium* would have increased in the time that *you* have not been paying it, *you* will need to pay the increased amounts
- *You* provide *us* with a new direct debit instruction so *we* can collect future *plan premiums*
- *You* and any other *person covered* by the *plan* completes a reinstatement application form. This is so that *we* can *underwrite your* request. *We* may offer *you* revised terms, or decline *your* request. 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.

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

D1.3 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 Protector.

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. The premium for the person who claimed will not reduce.

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

D1.4 How your Vitality Status affects your plan premiums

Your plan premium may change as a result of *your Vitality Status*. *We* will apply these changes on *your plan anniversary* in addition to any other changes that are due.

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* premium, see provision E2.

D2. GUARANTEED PREMIUMS

Your premiums are guaranteed. A guaranteed premium is one that will only change as a result of choices that *you* make.

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

- If *you* change *your plan*
- If *you* make a claim
- Depending on *your Vitality Status* (See provision E)

D3. 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

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.

D3.1 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 increase *your* Income Protection 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

D3.2 Removing or reducing covers

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

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 changes to *your* premium due to Vitality Optimiser

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 see provision D3.6.

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.

D3.3 Removing a person covered from a joint life plan

If *you* have a *joint life plan*, *you* can remove either of the people covered from it. If *you* do, the *plan* will continue as a *single life plan* for the remaining *person covered*, as long as that person has Life Cover.

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 changes in premium as a result of Vitality Optimiser.

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*.

D3.4 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*. *You* cannot change the term of individual covers within the *plan*; all the covers must have the same term.

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

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

If *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 Income Protection Cover or Waiver of Premium on Incapacity.

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.

D3.5 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.

D3.6 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 continue in place, unless *you* separately cancel it. The fee charged for *Vitality Plus* may also change.

D4. 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*

D4.1 Who we will pay the benefit to

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

D4.2 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.

D4.3 What we need before we can settle a claim

For a Life Cover claim, *we* will need proof that the *person covered* has died. *We* may also need proof of the age(s) of the person(s) covered, if *we* have not already received it.

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 any claim under Optional Serious Illness Cover for *Children*, *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.

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

D4.4 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*

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 Protector

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 Cover or Waiver of Premium on Incapacity

If *you* have a special definition of incapacity or *you* are a *houseperson* 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*.

D4.5 Making a claim when you are abroad

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

D4.6 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 Protector
- Income Protection Cover
- Optional Serious Illness Cover for *Children*
- Mortgage Free Cover
- Waiver of Premium on Incapacity

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

Exclusions for Life Cover

Exclusions for *suicide*

We will not pay a claim for Life Cover if one of the people covered dies as a result of *suicide* within 12 months of:

- The *start date* of the Life Cover
- The date it was 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 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 Protector

Appendix 1 explains the exclusions that apply to claims for specific illnesses under Serious Illness Cover Protector.

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 1 for Serious Illness Cover Protector. 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 Protector. If *we* have, and *you* make a claim for another *body system category* or condition, *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 Mortgage Free Cover

Mortgage Free Cover provides limited Life Cover or Serious Illness Cover Protector or both, depending on *your plan*. The exclusions that apply to Life Cover and Serious Illness Cover Protector, apply in the same way to Mortgage Free Cover, as appropriate.

Exclusions for Optional Serious Illness Cover for Children

Appendix 1 explains the exclusions that apply to claims for specific illnesses under Optional 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 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 for Guaranteed Insurability options

If *you* used *your* Guaranteed Insurability options to increase or change the *fixed term* of *your* cover, *we* will not pay a claim if the illness or disability causing the claim:

- Was known when *you* used *your* Guaranteed Insurability options, or
- Would have resulted in *us* paying a *benefit* before *you* used *your* Guaranteed Insurability options.

Exclusions for Family Benefit

We will not pay the *benefit* if:

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

In addition, no claim can be made for Complications of Pregnancy or Specified Congenital Condition until *your* Serious Illness Cover Protector has been in force for at least 9 months.

D5. 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.

D5.1 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 changes *you* made to *your joint life plan*
  - Any annual changes to *your* premium as a result of Vitality Optimiser

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*.

D5.2 How the covers change

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

- Income Protection Cover

However, *we* will:

- Remove Life 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 it is the only *benefit* left on the *plan*.

Serious Illness Cover Protector 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 Protector 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 Protector 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 they will need to set up a new *plan*. *We* will base any new Life 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*.

E. HOW VITALITY REWARDS YOU FOR BEING HEALTHY

The *Vitality Programme* helps *you* improve *your* health – and saves *you* money at the same time. It 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 plan premium* may change on each *plan anniversary*. *Your plan schedule* indicates whether *you* have chosen Vitality Optimiser.

Vitality Optimiser 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 each *plan anniversary*. The following table shows *you* how *your plan premium* can change:

We will allow *your plan premium* to reduce below *our* normal allowable minimum if the reduction is a result of Vitality Optimiser.

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 of Premium on Incapacity could also change (see provision D1).

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

E3. VITALITY BENEFITS ON YOUR PLAN

E3.1 Vitality Benefits for plans with Vitality Optimiser

Vitality Benefits will only be available if *you* have chosen Vitality Optimiser – this will be 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 Vitality Optimiser now.*

E3.3 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
- 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*,
- Split a *joint life plan* into two *single life plans*,
- 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* includes *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* includes *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*.

** 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 Vitality Optimiser now.*

E3.4 Cancelling your Vitality Benefits

If *your Vitality Plus* or *Vitality Select* is cancelled, Vitality Optimiser will be removed from *your plan* and *your* premiums will change as described in provision D3. Please refer to the separate terms and conditions for more information on the *Vitality Programme*.

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

E4. 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* are 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 plan* (see provision D5)
- *Your plan account* reduces to zero after a claim
- 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.org.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 *benefits* 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*, 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 services.

Processing claims

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

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

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

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

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

Marketing

Vitality Corporate Services Limited would like to send *you* information about *our* products and future products, which currently include health 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 PROTECTOR (SEE PROVISION C1).

This *plan* follows the ABI 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 – 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 10^9/L
- Platelets less than 50 x 10^9/L
- Reticulocytes less than 20 x 10^9/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.

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 10^9/L
- Platelets less than 20 x 10^9/L
- Reticulocytes less than 20 x 10^9/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
- Moderately Severe Aplastic Anaemia
- Mastectomy for Carcinoma in-situ of the Breast

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

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4.

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 (other than those stated 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 D4.6 (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

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.

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.

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 misuse

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.

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 due to Cardiac Arrest

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

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 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 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**
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of greater than 25 mm
- Heart attack resulting in a *permanent* ejection fraction of 39% or less whilst on *optimal therapy**
- 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**
- Hypertrophic Cardiomyopathy - resulting in maximal left ventricular wall thickness of between 15mm and 25mm
- Heart attack resulting in a *permanent* ejection fraction of between 40% and 45% whilst on *optimal therapy**
- 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
- *Permanent* 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

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4.

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 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 D4.6 (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 - *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 - *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 – 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 - *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 - *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 – *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 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 current or previous 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, *benefits* will be paid only when there is an inability to perform the *functional activity tests* see provision D4.4. *Alcohol* or *drug abuse* is excluded.

Paralysis of a limb

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

Paralysis of limbs

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

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 – *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*.

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 – *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 D4.4.

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 D4.4.
- 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 D4.4.
- 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 D4.4
- 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**
- Dementia – *resulting in permanent symptoms**
- Devic's Disease
- 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 C1.5.

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

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4.

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.

- 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 D4.6 (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.

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.

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 misuse
- 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
- At least one resection of a segment of small bowel

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

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4.

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 D4.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.E CONNECTIVE TISSUE DISEASES CATEGORY – SPECIFIED CONDITIONS OF DEFINED SEVERITY

1 DEFINITIONS

For the purposes of this *plan* other diseases which are not specifically named such as sero-negative arthritis, psoriatic arthritis or osteoarthritis are not covered by this *plan*, but complications of these diseases may be paid out should criteria be met under any of the other categories of illnesses.

Giant Cell Arteritis - of specified severity

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.

Polyarteritis Nodosa - of specified severity

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 - of specified severity

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 - of specified severity

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) - of specified severity

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) - of specified severity

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 - of specified severity

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 D4.4.

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 D4.4.

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 D4.4.

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 D4.4.

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 D4.4.

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4.

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 D4.6 (Exclusions)
- Any exclusion contained within the definition of any named condition.

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.

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 below.

Partial Nephrectomy

Undergoing the surgical removal of at least 30% of the mass of one kidney as a result of documented disease or trauma. If the surgical removal is due to cancer of the kidney, only one claim can be made for whichever of the conditions is placed at the highest severity level, see provision 1 f) 2 below. Biopsy is excluded.

Severe Chronic Renal Impairment

The impairment in renal function such that the estimated glomerular filtration rate is below 15 mls/ litre/min/1.73 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

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4

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 D4.6 (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 49% 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.

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

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4.

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 D4.6 (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 C1 and D4.

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 D4.6 (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

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

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4.

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 D4.6 (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.

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.

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

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4.

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 D4.6 (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.

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

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4.

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 D4.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.L 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 C1 and D4.

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 D4.6 (Exclusions)
- Any exclusion contained within the definition of any named condition
- Any exclusion applied specifically to *your plan*

1.M 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):

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

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.

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

3 EVIDENCE REQUIRED IN THE EVENT OF A CLAIM

This should be read in addition to and in connection with provision C1 and D4.

Any 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 m) 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 D4.6 (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 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**

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 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 D4.4).

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 ever again* (listed in provision D4.4).

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.

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 D4.4.

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 D4.4.

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 four *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 C1 and D4.

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 *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 1m) 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 D4.6 (Exclusions)
- Any exclusion within the definition of any named condition
- Any exclusion applied specifically to *your plan*

APPENDIX 2

ILLNESSES AND CONDITIONS IMPACTED BY BOOSTER

With Booster, in the event of a claim for a Serious Illness Cover Protector condition listed below *we* will increase the lump sum *we* pay *you* to 100% of *your* Serious Illness Cover Protector amount. This Appendix lists the conditions to which Booster applies (see Provision C1.3). For details of the definitions for these conditions please refer to Appendix 1.

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

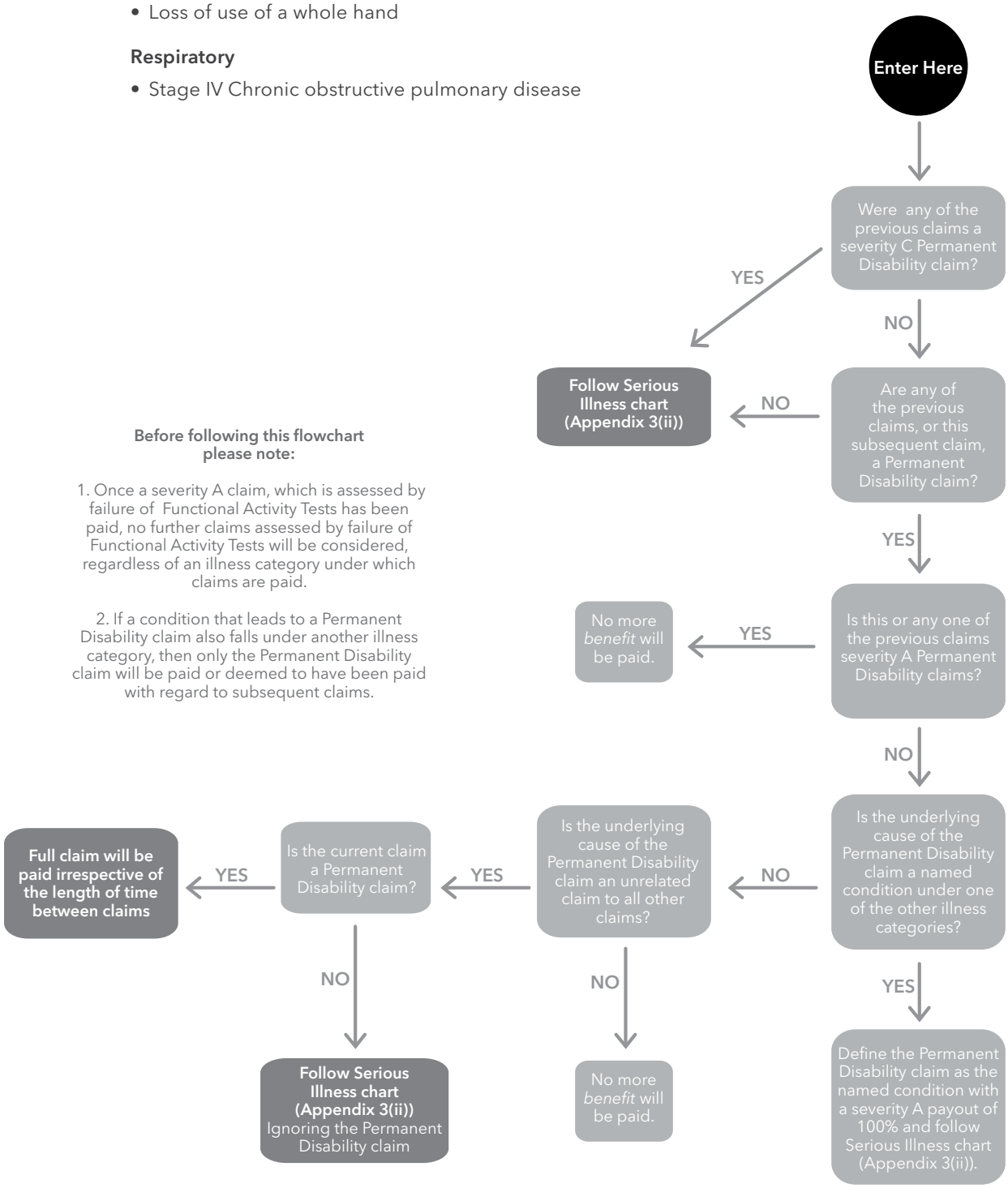
Respiratory

- Stage IV Chronic obstructive pulmonary disease

Before following this flowchart please note:

1. Once a severity A claim, which is assessed by failure of Functional Activity Tests has been paid, no further claims assessed by failure of Functional Activity Tests will be considered, regardless of an illness category under which claims are paid.

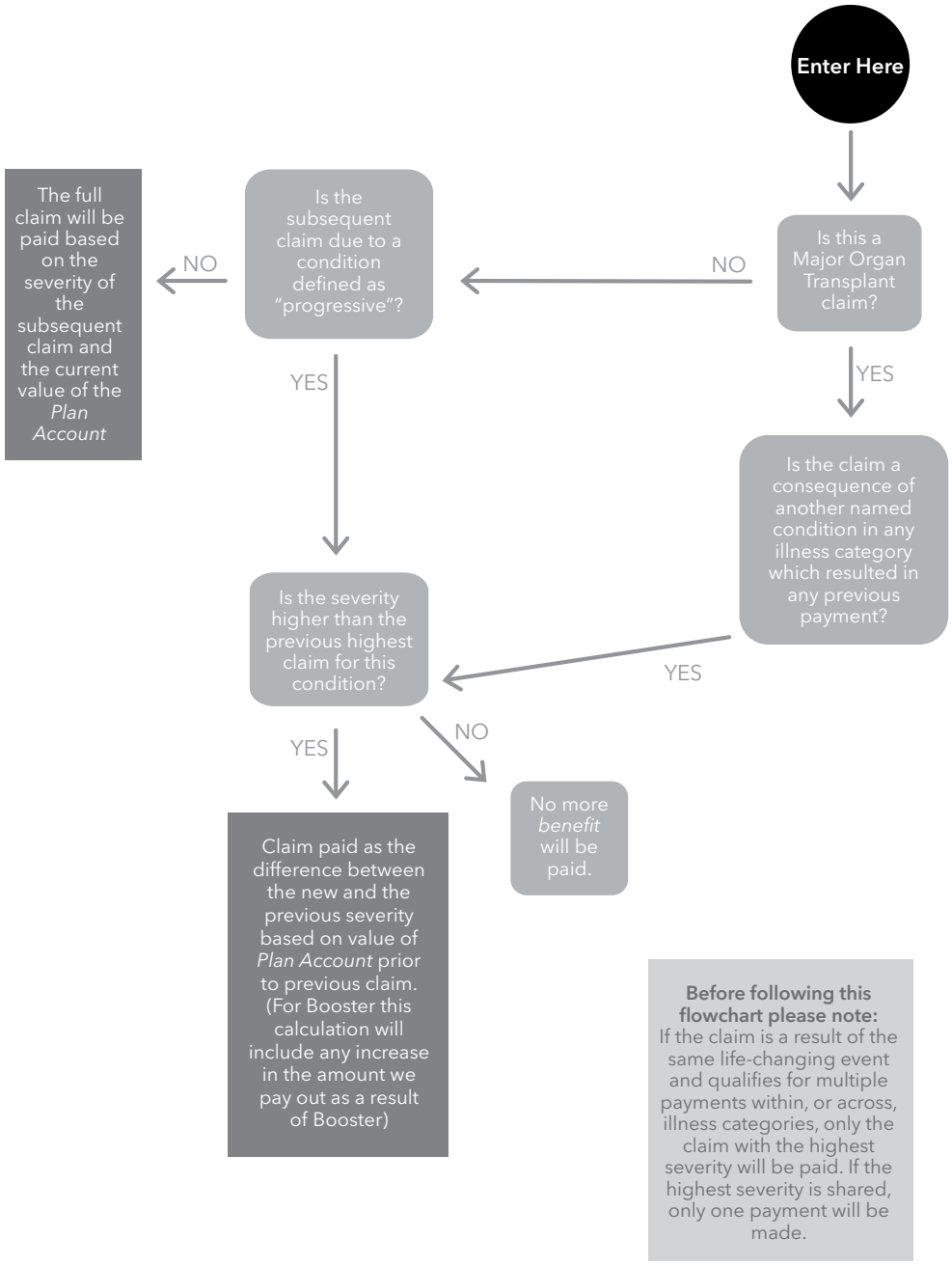
2. If a condition that leads to a Permanent Disability claim also falls under another illness category, then only the Permanent Disability claim will be paid or deemed to have been paid with regard to subsequent claims.



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

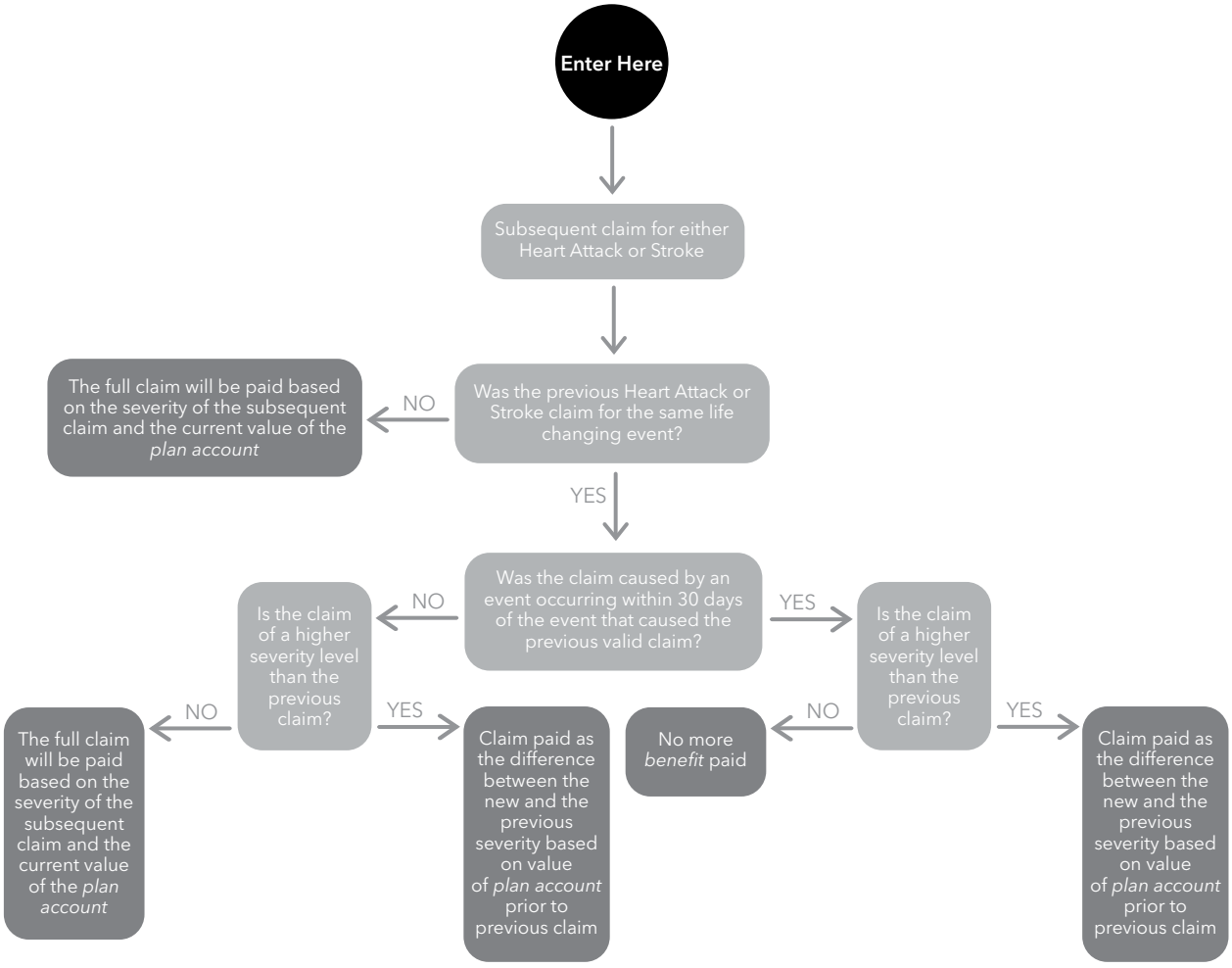
Stroke and nervous systems

- 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



Note: this does not apply to Heart Attack and Stroke. Please refer to Appendix 3 (iii)

- Bilateral hemianopia
- Coma
- Creutzfeldt-Jakob disease - resulting in *permanent* symptoms
- Dementia - resulting in *permanent* symptoms
- Devic's Disease
- Encephalitis - resulting in *permanent* symptoms
- Guillain-Barré Syndrome – of specified severity



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

- 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
- Spinal Stroke
- 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

Find out more.

For more information please speak to your adviser or visit our website vitality.co.uk/life

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