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Serious Illness Cover Plan Provision Supplement.

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Serious Illness Cover Provisions.

This document is sent to *you* because *you* have upgraded *your* Serious Illness Cover. All sections provided in this document replaces the corresponding sections in *your* existing *plan* provisions, unless *we* say otherwise.

All other sections in *your* existing *plan* provisions are still applicable to *your plan*. In the event of a conflict between this supplement and *your* existing *plan* provisions, this supplement shall prevail to the extent of any such inconsistency.

We have put some words in *italics*. *We* explain what *we* mean by these words in the Definitions section.

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*. Alternatively, *you* can also write to *us* at VitalityLife, Sheffield, S95 1BW.

Please contact us on 0345 601 0072 or speak to your adviser if you would like this document in large print or Braille.

As *you* have upgraded *your plan*, the following *benefits* and covers will have changed. *Your plan schedule* shows if any of these *benefits* and covers are included on *your plan*.

- Serious Illness Cover;
- Child Serious Illness Cover;
- Family Income Cover;
- Later Life Options.

More information about how these *benefits* and covers have changed can be found in this supplement.

1. Serious Illness Cover.

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

The lump sum *we* pay *you* will be a percentage of *your* Serious Illness Cover between 5% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from levels A to G. For more about severity levels, see 'How much *we* will pay', at section 1.3.

1.1 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; and
- *You* must survive for at least 14 days after the date of the *life-changing event* which causes *you* to claim. If *you* make a *permanent* disability claim, *you* must survive until the date when *we* confirm that *you* are totally and *permanently* disabled. For more about *permanent* disability claims, see Appendix 1.

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

How we will assess your claim if your occupation has changed

You do not need to tell *us* if *you* change *your occupation* while *you* are covered under *your plan*. *We* will assess any claims *you* make according to the *occupation you* were in immediately before *you* claimed. If *we* would not normally use an *own occupation* definition for that *occupation*, then *we* may use *functional activity tests* to assess *your* claim. For more about *functional activity tests*, see section 3.1.

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.

1.2 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	Section 1.1
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	Section 1.7
We do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim	
We do not receive the medical evidence *we* need from *your* General Practitioner and any specialists who are treating *you*	Section 1.1
We are not satisfied that the *serious illness* that has led to *your* claim occurred either while *we* were providing *you* with Serious Illness Cover or was disclosed to *us* and *we* excluded it from *your* cover when *you* applied	
Your Serious Illness Cover expires before the *life-changing event* which leads to *your* claim	*Your plan schedule*

1.3 How much we will pay

The amount *we* will pay depends on:

- How severe *your* condition is;
- The type of cover *you* have;
- The amount of cover *you* have; and
- Whether *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster.

How severe your condition is

The lump sum *we* pay *you* will be a percentage of *your* Serious Illness Cover between 5% and 100%. That percentage will depend on how severe *your* illness is – based on a scale from A to G.

Severity level	The percentage of your cover we will pay
A (most severe)	100%
B	75%
C	50%
D	25%
E	15%
F	10%
G (least severe)	5%

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

The type of cover

You are covered for severity levels A to E unless *you* have chosen Serious Illness Plus, in which case *you* are covered for all the severity levels - from A to G.

Your plan schedule shows whether *you* have:

- Serious Illness Cover;
- Serious Illness Cover Plus; or
- Mortgage Serious Illness Cover.

The amount of cover

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

Serious Illness Cover Booster

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

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

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

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

- *Your* age at the time *you* claim; and
- The number of dependent *children* covered under Child Serious Illness Cover on *your plan*.

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

Age attained at date of diagnosis	What percentage of your Serious Illness Cover we will pay	Age attained at date of diagnosis	What percentage of your Serious Illness Cover we will pay
16 - 24	200	45	147.5
25	197.5	46	145
26	195	47	142.5
27	192.5	48	140
28	190	49	137.5
29	187.5	50	135
30	185	51	132.5
31	182.5	52	130
32	180	53	127.5
33	177.5	54	125
34	175	55	122.5
35	172.5	56	120
36	170	57	117.5
37	167.5	58	115
38	165	59	112.5
39	162.5	60	110
40	160	61	107.5
41	157.5	62	105
42	155	63	102.5
43	152.5	64 and older	100
44	150		

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

Serious Illness Cover Booster does not apply to claims for Child Serious Illness Cover.

1.4 What happens if a single life-changing event causes you to claim for more than one serious illness

If a single *life-changing event* causes *you* to have valid claims for more than one *serious illness*, *we* will only pay one claim. *We* will pay the claim for the illness with the highest severity level. Any *serious illness*, that resulted from a single *life-changing event*, that progresses will be treated as a *progressive claim*.

1.5 What happens if a single life-changing event causes claims for more than one person covered

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

We will calculate each payment using the amount of the *plan account* at the time of the *life-changing event*. This means that the total amount *we* pay across all the claims might be more than the value of the *plan account*. If this happens, the *plan account* may reduce to zero – unless *you* have Mortgage Serious Illness Cover or a Protected Cover option. *Your plan schedule* shows if *your plan* includes this.

1.6 Claims under Mortgage Serious Illness Cover

If *your* claim is for a condition that is included in Appendix 2.1 and *your plan schedule* indicates that *you* have Mortgage Serious Illness Cover, the lump sum *we* pay *you* will be increased to 100% of *your* amount of Mortgage Serious Illness Cover. This does not apply to claims for Child Serious Illness Cover.

Additionally, any payment for a Severity A or a condition listed in Appendix 2.1 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 remaining will be *your* chosen percentage of the remaining *plan account*; or
- If the amount *we* have paid *you* is equal to the value of *your plan account*, *your plan* will end.

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

1.7 What happens if you need to make a subsequent claim

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

When *we* make payments under Serious Illness Cover, the value of *your plan account* reduces by the amount *we* have paid *you*. If the amount *we* have paid *you* is equal to or greater than the value of *your plan account*, *your* Serious Illness Cover will come to an end. This works differently if *you* have Mortgage Serious Illness Cover or a Protected Cover option. *Your plan schedule* shows if *your plan* includes this.

The maximum amount available for future claims will be the remaining value of the *plan account*.

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.

Subsequent claims

If *you* have already claimed, *we* will classify any subsequent claims *you* make as either a *progressive claim* or an *unrelated claim*.

Progressive claims	
Definition	A *progressive claim* occurs when: **1.** A *person covered* has a *life-changing event* that causes a *serious illness;* **2.** They make a claim for that *serious illness; and* **3.** They later make a claim for the same illness, or another *serious illness* that was caused by the same *life-changing event.*
When *we* won't pay	No further payment will be made if: • the severity of the *progressive claim* is the same as or lower than the severity level of the previous claim; or • if the previous claim was for a condition listed in Appendix 2.1. and the *progressive claim* is also for a condition that is listed in Appendix 2.1 or is for a severity level A condition.
When *we* will pay	If the severity level of *your progressive claim* is higher than the severity level of *your* previous claim, *we* will make another payment.
How *we* calculate the amount *we* will pay	*We* will base the amount *we* pay on the increase in severity from the previous claim to the new claim. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your progressive claim* is for a condition listed in Appendix 2.2 *we* will calculate the amount *we* will pay as follows: • *We* will calculate the amount *we* pay for a condition listed in Appendix 2.2. When *we* do this *we* will use *your* age at the date *you* meet the definition for the condition for which *you* are making *your progressive claim*; and • *We* will subtract from this the amount *we* have already paid *you* for the previous claim. *We* will base the amount *we* pay on the value of *your plan account* prior to the previous claims. *We* will also pay interest for the period from the previous 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; and* **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.

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

a. 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*.

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

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

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

c. Subsequent permanent disability claims

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

- If *we* have made a previous payment for a *permanent* disability claim, and *your* condition then progresses to a higher severity level within that category, *we* will:
  - Pay an amount based on the increase in severity from the previous claim to the new one. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your* claim is for a condition listed in Appendix 2 the amount *we* will pay will include any increase as a result of Serious Illness Cover Booster; and
- If *we* have made a previous payment under any *body system category* other than *permanent* disability, and *your* condition then progresses so it becomes valid under the *permanent* disability category, *we* will:
  - Pay an amount based on any increase in severity from the previous claim to the new one. If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster and *your* new claim is for a condition listed in Appendix 2 the amount *we* will pay will include any increase as a result of Serious Illness Cover Booster; and
  - Manage any subsequent claims on the basis that this was a *permanent* disability claim

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

- Under the same *body system category* that the underlying cause of *your permanent* disability claim is listed under, or
- Under a different *body system category*.

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

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

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

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

1.8 Cancer Relapse Benefit

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

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

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

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

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

1.8.1 When we will pay the benefit

1. Subsequent claims under Cancer Relapse Benefit

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

Please see section 1.7 for details on how *we* pay progressive and unrelated subsequent claims.

2. Lump sum increase for subsequent claims

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

Definition of Cancer - For Cancer Relapse Benefit

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

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

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

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

1.8.2 When we will not pay the benefit

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

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

1.8.3 How Cancer Relapse Benefit affects the plan account

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

1.9 How your cover continues after a claim for serious illness

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

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

We calculate the amount available for future *serious illness* claims by subtracting the total amount paid for claims under Serious Illness Cover (including Serious Illness Cover Booster) from *your plan account*. The amount of *your* Serious Illness Cover will be a chosen percentage of the *plan account*. This will work differently if *you* have Mortgage Serious Illness Cover or a Protected Cover option. *Your plan schedule* shows if *your plan* includes this.

For joint life plans

Payments *we* make under Serious Illness Cover will reduce the value of *your plan account* by that amount – unless *you* have Mortgage Serious Illness Cover or a Protected Cover option. *Your plan schedule* shows if *your plan* includes this.

If the *plan account* does reduce, then:

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

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

There is a maximum total amount of *benefit you* can receive under Serious Illness Cover (including any payments from Cancer Relapse *Benefit*). This is the lower of:

- £3,000,000; or
- Three times *your* initial amount of Serious Illness Cover – adjusted to reflect:
  - Any indexation increases that occurred up to the date of *your* first *serious illness* claim; and
  - Any changes *you* have made to *your* amount of cover.

On *joint life plans* this maximum applies to each *person covered* separately. The maximum *benefit* includes any and all payments *we* make for any and all conditions covered as set out in any Appendix to the *plan* provisions.

If *you* reach this maximum *benefit* amount, *we* will not accept any further *serious illness* claims and Serious Illness Cover will be removed from *your plan*. If *we* do that, *we* will reduce *your* premiums accordingly. *Your* Later Life Option, including Funeral Cover, will also be removed from *your plan*.

If *you* are also covered by other policies issued by *us*, the overall maximum amount that *we* will ever pay in respect of a *person covered* is £3,000,000. This includes any and all payments *we* make for any and all conditions covered as set out in any Appendix to the *plan* provisions. This overall maximum amount is increased to £4,000,000 if *your plan schedule* indicates that *you* have chosen Mortgage Serious Illness Cover or have included Serious Illness Cover Booster.

This applies separately to each *person covered*. *You* will no longer have to pay a premium for those covers. If *we* have not yet paid the maximum *benefit*, but a future claim might breach it, *we* might restrict *your* cover.

1.10 Family Benefit

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

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

1.10.1 When we will pay the benefit

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

a) Complications of Pregnancy

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

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

b) Specified Congenital Conditions

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

- Cerebral Palsy - a definite diagnosis of Cerebral Palsy by an *appropriate medical specialist;*
- Cystic Fibrosis – a definite diagnosis of Cystic Fibrosis by an *appropriate medical specialist;*
- Downs Syndrome – a definite diagnosis of Downs Syndrome by an *appropriate medical specialist;*
- Edwards Syndrome – a definite diagnosis of Edwards Syndrome by an *appropriate medical specialist;*
- Osteogenesis Imperfecta – a definite diagnosis of Osteogenesis Imperfecta by an *appropriate medical specialist;*

- Patau Syndrome – a definite diagnosis of Patau Syndrome by an *appropriate medical specialist;*
- Spina Bifida – a definite diagnosis of Spina Bifida by an *appropriate medical specialist; or*
- Surgical treatment of Craniosynostosis - surgical treatment of Craniosynostosis by a Consultant Neurosurgeon.

c) Children's Funeral Contribution

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

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

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

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

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

We will only pay the *benefit* if:

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

1.10.2 When we will not pay Family Benefit

We will not pay the Family *Benefit* if:

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

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

For the Complications of Pregnancy conditions listed in section 1.10.1.a that have been marked with an asterix, *we* will only make one payment per pregnancy, rather than per *child*.

In addition, no claim can be made for any Complications of Pregnancy or Specified Congenital Conditions which existed (whether or not a diagnosis was made or any symptoms were evident) within the first 9 months the Family *Benefit* has been on *your plan*.

1.10.3 How much we will pay

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

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

1.10.4. When your Family Benefit will end

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

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

2. Other Covers.

2.1 Later Life Options

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

Your plan schedule shows if *you* have included Dementia and FrailCare Cover or Dementia and FrailCare Cover Plus on *your plan* and, where *you* have joint life cover, the persons for which the cover is available on. Cover under *your* Later Life Option will automatically begin after *your* Serious Illness Cover's *date of expiry*. When *you* are covered under *your* Later Life Option, *we* will pay a lump sum if *you* are diagnosed with an illness or condition that *we* cover and which meets *our* definition of that condition. *We* set these conditions out in Appendix 3.

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

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

2.1.1 How much we will pay

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

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

How severe your condition is

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

Severity level	The percentage of *your* cover *we* will pay
A	100%
B	75%
C	50%
D	25%

Appendix 3.1 shows which severity levels apply to which conditions.

The amount of cover

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

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

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

Your Later Life Option amount will be adjusted for any claims *you* make under Serious Illness Cover and any changes *you* make to *your* Serious Illness Cover amount. For more about how a claim affects *your* Later Life Option, see provision 2.1.10. For more about how changes to *your* Serious Illness Cover affect *your* Later Life Option, see provision 2.1.13.

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

2.1.2 When we will pay the benefit

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

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

- *You* must be diagnosed with a condition that *we* cover. *Your* condition must meet one of the definitions set out in Appendix 3.1. *We* will use the criteria in Appendix 3.1 to assess *your* claim – irrespective of any changes to generally known definitions of medical terms, or to the way particular conditions are usually treated; and
- *We* must have agreed to cover *you* for the condition *you* claim for. *Your plan schedule* shows whether *we* have excluded any conditions from *your* cover. If *we* have, *we* will not pay a claim for that condition.

We will ask *your* General Practitioner, and any *appropriate medical specialists* who are treating *you*, for medical evidence. *We* will need different types of information for different types of illness or conditions. For more about this, see Appendix 3.1. *Our* Chief Medical Officer will use this evidence to determine whether *your* claim is valid.

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

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

2.1.3 When we will not pay

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

- Cover under *your* Later Life Option has not begun;
- *You* suffer from a condition *we* do not cover;
- *Your* condition does not meet *our* definition for that condition;
- The claim is due to a condition what *we* have excluded from *your* Serious Illness Cover;
- *We* do not receive written notice that *you* want to claim within six months of the *life-changing event* which causes *you* to claim;
- *We* do not receive the medical evidence *we* need from *your* General Practitioner and any *appropriate medical specialists* who are treating *you*;
- *You* do not survive for at least 14 days after the date of the *life-changing event* which caused *you* to claim; or
- *You* have already claimed for a condition under *your* Serious Illness Cover which is regarded as a related condition under *your* Later Life Option. All related conditions are listed in Appendix 3.2.

2.1.4 What happens if your claim meets multiple definitions at one time

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

2.1.5 What happens if you need to make a subsequent claim

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

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

2.1.6 What happens if you claim for a condition during your Serious Illness Cover term

Any claims made under Serious Illness Cover will reduce *your* Later Life Option amount in proportion to the reduction in *your* Serious Illness Cover amount. This works differently if *you* have Mortgage Serious Illness Cover or a Protected Cover option. *Your plan schedule* shows if *your plan* includes this.

2.1.7 Your Later Life Option premium

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

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

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

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

Your Vitality Status will impact how *your* premiums, and *your* Dementia and FrailCare Cover Plus premiums will change.

This works differently if *you* have made a successful claim under *your* Later Life Option. Please see provision 2.1.10 for more information on this.

2.1.8 When your Later Life Option will end

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

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

2.1.9 Funeral Cover

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

2.1.9.a How much we will pay

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

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

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

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

Your Funeral Cover amount will be adjusted for any changes to *your plan account*. This includes claims *you* make under Serious Illness Cover, or any changes *you* make to *your* Life Cover amount. For more about how claims affect *your plan account* or how changes to *your plan* affect *your* Funeral Cover, see provisions 1.9 and 2.1.13 respectively. Claims under Serious Illness Cover will reduce *your* Funeral Cover amount in proportion to the reduction in the *plan account*. This works differently if *you* have Mortgage Serious Illness Cover or a Protected Cover option. *Your plan schedule* shows if *your plan* includes this.

If *your* Life Cover is indexed, *your* Funeral Cover amount will also increase at each *plan anniversary* and may increase above the maximum amount available at the start of *your plan*.

2.1.9.b Your Funeral Cover premium

No additional premium is payable for Funeral Cover during *your* Life Cover term. *Your* Life Cover premium will continue to be payable when cover under Funeral Cover begins. After its *date of expiry*, *your* Life Cover premium will reduce in proportion to any limitation on *your* Funeral Cover amount resulting from the maximum amount.

If *your plan account* includes indexation, *your* Funeral Cover will also be indexed. This means both *your* cover amount and premium will continue to increase with indexation.

The amount by which *your* premium will increase will depend on *your* age and the percentage rise in the *Retail Prices Index* at the time *your* Funeral Cover increases. *You* can remove indexation from *your plan* at any time.

Your premium will continue to change by *your Vitality Status*. This works differently if *you* have made a successful claim under *your* Later Life Option. Please see provision 2.1.10 for more information on this.

2.1.9.c When your Funeral Cover will end

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

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

2.1.10 What happens if you claim under your Later Life Option

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

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

If *you* make a successful claim under *your* Later Life Option, *we* will not increase *your plan premium* by *your Vitality Status*.

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

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

2.1.11 What happens if your Serious Illness Cover and Life Cover have different terms

If *your* Serious Illness Cover term ends before *your* Life Cover term, cover under *your* Later Life Option will begin as described in 2.1.2. *Your* Life Cover will continue until it reaches its *date of expiry*, after which *you* will be covered under Funeral Cover. Premiums will be payable for *your* Later Life Option and Funeral Cover once *you* are covered under each individual cover. For more information about *your* Later Life Option and Funeral Cover premiums, see provision 2.1.7 and 2.1.9.b respectively.

2.1.12 How your Later Life Option works on joint life plans

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

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

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

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

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

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

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

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

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

- Reduce *your* Serious Illness Cover term below the minimum required *plan* term;
- Remove Serious Illness Cover; or
- Remove Optimiser.

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

- The option is removed; or
- *Your plan* is cancelled.

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

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

2.2 How other covers and benefits have changed from your upgrade

When *you* upgrade *your plan*, other related *benefits* and covers will also be upgraded automatically.

This section does not replace any section in *your* existing *plan* provisions but merely provides details of how each related *benefit* and cover has been upgraded.

2.2.1 Illnesses and conditions covered

As a result of *your* upgrade, *we* have added new conditions and enhanced existing ones on the following *benefits* and covers:

- Child Serious Illness Cover - please refer to Appendix 1; or
- Family Income Cover - please refer to Appendix 1.

Your plan schedule shows which of the above *benefits* and covers are included on *your plan*.

3. Claiming a benefit.

The following section sets out the relevant general exclusions and how *we* assess whether *you* are incapacitated for certain claims.

3.1 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 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 this provision); and
- *Work tasks*.

Types of functional activity tests

Tasks designed to assess whether *you* can look after yourself ever again (also called activities of daily living)	How *we* define this activity
Washing	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means
Getting dressed and undressed	The ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances
Feeding yourself	The ability to feed yourself 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	Where to find more information
Walking	The ability to walk more than 200 metres on a level surface
Climbing	The ability to climb up a flight of 12 stairs and down again, using the handrail if needed
Lifting	The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table
Bending	The ability to bend or kneel to touch the floor and straighten up again
Getting in and out of a car	The ability to get into a standard saloon car, and out again
Writing	The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard

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

Knowing which tests are relevant to your claim

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

Serious Illness Cover

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

If *you* are aged 65 or over when *you* make *your* claim *we* will assess *your* claim based on whether *you* can perform *activities of daily living*.

If *your* claim is for *your child* under Child Serious Illness Cover, *we* will assess *your child's* condition based on total *permanent* disability for *children* in Appendix 1.

Waiver of Premium on Incapacity

If *you* have the 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 in *your* existing *plan* provisions and section 3.1 of this supplement.

For any claim caused by a condition that arose before *you* upgraded *your plan*, *we* will assess *your* inability to perform a particular activity based on *your* existing *plan* provisions. Additionally, for any claim caused by a condition that arose after *you* upgraded *your plan*, *we* will assess *your* inability to perform a particular activity based on this supplement.

3.2 Exclusions

The following section shows the general exclusions that apply to the *benefits* and covers below.

Please see *your* existing *plan* provisions for the general exclusions that apply to all other *benefits* on *your plan*.

Your plan schedule shows which *benefits* and covers are included on *your plan*.

General exclusions

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

- Serious Illness Cover;
- Family Income Cover (payable on diagnosis of a *serious illness*);
- Child Serious Illness Cover; or
- Later Life Options.

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

Exclusions for Serious Illness Cover and Family Income Cover (payable on diagnosis of a serious illness)

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

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

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

We will only accept a claim under *your* existing *plan* provisions if the condition *you* are claiming for occurred after the *start date* of *your plan*, or *you* disclosed it to *us* and *we* did not exclude it from *your* cover when *you* applied. Additionally, *we* will only accept a claim under this provision if the condition *you* are claiming for occurred after *you* upgraded *your plan*, or *you* disclosed it to *us* and *we* did not exclude it from *your* cover when *you* upgraded.

Exclusions for Child Serious Illness Cover

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

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

Exclusions for Later Life Options

Appendix 3 explains the exclusions that apply to claims for specific illnesses under Later Life Options.

We will not pay a *benefit* for any illness or condition that is not listed in Appendix 3.1. This exclusion applies even if the generally accepted definition of a medical term or the treatment of a condition changes after the *start date* of *your plan*.

If *you* claim for a condition under Serious Illness Cover during the life of *your plan*, *you* will not be able to claim for that condition, or any related conditions, under Later Life Options. Related conditions are listed in Appendix 3.2.

We may have excluded specific conditions from *your* Later Life Options. If *we* have, and *you* make a claim, *we* will not pay a *benefit* if *our* Chief Medical Officer believes that *your* illness or condition is a direct result of the conditions that *we* have declined or excluded.

We will only accept a claim if the condition *you* are claiming for occurred after *you* upgraded *your plan*, or *you* disclosed it to *us* and *we* did not exclude it from *your cover* when *you* upgraded. Additionally, *we* will base any *benefit* on the cover amount that was in force at the time the condition, which *you* are claiming for, occurred.

Definitions.

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 section 3.1.

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; or/and
- 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; and
- Accepted by *our* Chief Medical Officer

Benefit

Money *we* pay to *you* if *you* make a successful claim under the *plan*.

Body system category

The category of *serious illnesses* that affect a particular body system, as outlined in the appendices.

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*, *step-child* or a *child you* are the legal guardian of; and
- Is looked after by, or financially dependent on, *you*

Civil Partner/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.

Date of expiry

The date a cover ends. The *date of expiry* of each of *your* covers is shown on the *plan schedule*.

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.

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

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.

Life-changing event

A single identifiable event or condition that causes *you* to make a claim.

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*.

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; and
- 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; and/or
- 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; and
- 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 Personal Protection *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 sections 1.4 to 1.7.

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 Optimiser in accordance with the separate Vitality terms and conditions for the healthy living part of *your plan*.

Plan schedule

The document *you* received when *you* upgraded *your plan*. It contains details of:

- 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; and*
- 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 Child Serious Illness Cover;
- The legal *adoption* of the relevant *child* (only for Child Serious Illness Cover); and
- The date the *planholder* became the legal guardian of the relevant *child* (only for Child Serious Illness Cover);
- The date that the *plan* is reinstated following non-payment of *plan* premiums.

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; and*
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.*

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.

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*.

Serious illness

An illness or condition that:

- Is defined in Appendix 1; and
- Meets *our* criteria for that illness or condition

The *serious illnesses* are divided into body system categories. These categories are set out in Appendix 1.

Simultaneous claims

Two or more *serious illness* claims that meet all of the following criteria:

- They are being made by more than one *person covered* or *child* under a *plan;*
- They are a result of the same *life-changing event; and*
- 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.

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 section 3.1. *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.

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; and*
3. They later make a second claim for another *serious illness* that was caused by a different *life-changing event*.

We/us/our

Vitality Life Limited.

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 of functional activities that help to show how able someone is to work. *We* may refer to these activities *you* make a claim to do with incapacity: *we* list these activities in section 3.1.

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 related benefits.

This appendix replaces the corresponding appendix in *your* existing *plan* provisions.

Any reference to the Definitions for Serious Illness Cover Appendix in *your* existing *plan* provisions will now refer to the following section.

Illnesses and Conditions – Definitions for Serious Illness related benefits (see section 1).

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 reticuloendothelial 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; and
- Any skin cancer (including cutaneous lymphoma) other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

Carcinoma in-situ

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

For the above definition, the following are not covered:

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

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

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

For the above definition, the following are not covered:

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

Moderately Severe Aplastic Anaemia

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

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

Mastectomy for Carcinoma in-situ of the Breast

Total removal of all the tissue of one breast for the treatment of carcinoma in-situ in the removed breast. Prophylactic mastectomy without histological evidence of cancer in-situ is not covered. *We* only cover mastectomy, any other surgical procedures such as lumpectomy and partial mastectomy are also excluded.

Multiple Myeloma

A malignant proliferation of plasma cells in the bone marrow with destruction of surrounding tissue on bone marrow examination. It must also cause a high level of abnormal proteins in the blood called paraproteinaemia demonstrated on protein electrophoresis. Monoclonal gammopathy of unknown significance will be excluded.

Myelodysplasia

Myelodysplasia is a clonal disorder of at least one cell line of the bone marrow causing insufficient number of normal blood cells.

Non-Melanoma Skin Cancer – of specified severity

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

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

For the above definition, the following are not covered:

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

Severe Aplastic Anaemia

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

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

2. Severity levels

How is severity measured?

The severity level determines the payment(s) *we* make. The severity of cancer is measured by staging at diagnosis, so the higher the stage at diagnosis the higher the initial *benefit*. If a cancer progresses, *we* will assess the progression of the cancer using the same staging criteria as will be used at diagnosis.

For example, if *you* are diagnosed with stage 1 breast cancer, this is stage 1 disease at diagnosis. If this metastasises (spreads, or invades different organs or parts of the body) *we* will reclassify the staging, even if *your* medical records still state 'stage 1 but with metastases to the bones'. In this example *we* will reclassify the claim as stage 4. Please tell *us* if *you* believe that the cancer has spread to other organs or parts of the body, *we* will then liaise with *your* Oncologist and/or other specialist.

For the purpose of this *plan we* will assess the staging of cancer using The International Union against Cancer TNM Classification of Malignant Tumours 7th edition (Pub.Wiley-Liss). *We* will use the group stages 1–4 as defined within this reference book to allocate the severities.

Leukaemia:

The severity of Chronic Lymphocytic 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; and
- 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; and
- 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; and
- 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; and
- Myelodysplasia classified as Low risk on the International Prognostic Scoring System

Severity Level G:

- Carcinoma in Situ;
- Non-Melanoma Skin Cancer – of specified severity.

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. 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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- Any exclusion applied specifically to *your plan*.

1.b Heart and Artery category – specified conditions of defined severity

1. Definitions

Angioplasty (Coronary) or PTCA (Percutaneous Transluminal Coronary Angioplasty)

PTCA or other percutaneous coronary artery procedures performed by a Consultant Cardiologist to dilate and treat a coronary artery stenosis. The procedure may or may not involve the use of a stent.

Angioplasty to correct Carotid Artery Stenosis

Therapeutic angioplasty with or without stent to correct symptomatic stenosis of the carotid artery.

Any Cardiac Condition resulting in a Reduced Ejection Fraction

Any cardiac condition causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 45% or less. There must be two measurements with an interval of at least six months for a claim to be considered.

Aorta Graft Surgery

The undergoing of, or inclusion on the NHS waiting list for, surgery for disease or traumatic injury to the aorta with excision and surgical replacement of a portion of the diseased or injured aorta with a graft.

The term aorta includes the thoracic and abdominal aorta but not its branches. For the above definition, the following are not covered:

- Any other surgical procedure, for example the insertion of stents or endovascular repair.

Balloon Valvuloplasty

The dilation of a stenotic valve of the heart by percutaneous balloon procedure performed by a Consultant Cardiologist.

By-pass Graft Surgery to 3 or more Coronary Arteries

The undergoing of, or inclusion on the NHS waiting list for, surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage to three or more coronary arteries with by-pass grafts.

Cardiomyopathy resulting in a Reduced Ejection Fraction

A disease of the heart muscle causing *permanent* reduction in the efficiency of the heart to act as a pump. There must be *permanent* reduction in the ejection fraction to at least 45% or less. There must be two measurements with an interval of at least six months for a claim to be considered. Alcoholic cardiomyopathy is specifically excluded.

Cardioversion for Cardiac Arrhythmia

The intentional therapeutic medically supervised application of an electrical shock, using at least 40 joules, to correct a documented and recorded arrhythmia of the heart.

Congestive Heart Failure

The inability of the heart muscle on either the right or left side of the heart, or both, to pump blood effectively resulting in a backflow into vessels supplying the heart. For the purposes of this *plan* this must be diagnosed by a Consultant Cardiologist and *optimal therapy* must have been established for at least 6 months. There must be at least 4 signs of congestive heart failure present for a claim to be considered.

The signs of congestive heart failure include:

- Presence of third heart sound;
- Jugular venous pressure above 6 cms;
- Rales present in both bases on auscultation;
- Cardiomegaly on chest x-ray;
- Grade 3, or gross ascites, associated with marked abdominal distension; or
- Severe oedema to a level above the knee

Coronary Angioplasty – with specified treatment

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

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

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

The following are not covered:

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

Coronary Artery By-pass Grafts

The undergoing of, or inclusion on the NHS waiting list for, surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

Emergency Intravenous Anti-arrhythmic therapy for Ventricular Tachycardia or Fibrillation

Documented Ventricular Tachycardia or Ventricular Fibrillation requiring admission to hospital for the treatment of intra-venous antiarrhythmic therapy.

Endovascular Repair of Aortic Aneurysm

The repair through endovascular methods of an aortic aneurysm with the replacement of a portion of the diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches.

Femoral Artery Aneurysm Repair

The undergoing of, or inclusion on the NHS waiting list for, surgical repair of an aneurysm of the femoral artery by surgery or by endovascular techniques.

Heart Attack

Death of heart muscle, due to inadequate blood supply that has resulted in the following:

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

For the above definition, the following are not covered:

- Other acute coronary syndromes;
- Angina without myocardial infarction; and
- 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 1 B) 1 above for a claim to be considered.

Hypertrophic Cardiomyopathy - of specified severity

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

For the above definition the following are not covered:

- Cardiomyopathy secondary to *alcohol or drug abuse*.

Iliac Artery Aneurysm Repair

The undergoing of, or inclusion on the NHS waiting list for, surgical repair of an aneurysm of the iliac artery by surgery or by endovascular techniques.

Infective Endocarditis

Endocarditis is the infection on the valves of the heart with vegetations (clumps of small clot and bacteria) visible on the echocardiogram.

There must be echocardiographic evidence of vegetation on the valves of the heart, and blood cultures must show bacterial growth in at least two samples taken at the same time. Endocarditis as a result of drug misuse is not covered.

Keyhole Coronary Artery Bypass Surgery

The undergoing of, or inclusion on the NHS waiting list for, surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts via a thorascope or mini thoracotomy.

Pericardectomy

The undergoing of, or inclusion on the NHS waiting list for, the surgical excision of part of the pericardium surrounding the heart via thoracotomy or sternotomy to relieve a constriction of the heart. Biopsy and aspiration of pericardial effusion is excluded.

Permanent Defibrillator Insertion

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

Permanent Defibrillator Insertion due to Cardiac Arrest

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

Permanent Pacemaker Insertion

The undergoing of, or inclusion on the NHS waiting list for, the *permanent* insertion of an artificial pacemaker to correct an abnormal rhythm of the heart. The abnormal rhythm of the heart must have been documented on electrocardiograph (ECG) and be available to *us*.

Severe Peripheral Vascular Disease

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

The following is not covered:

- Angioplasty.

Severe Vascular Disease affecting Multiple Systems

Severe vascular disease affecting the heart, kidney and/or brain. There must be at least 2 of the following:

- Stroke*,
- Left ventricular hypertrophy measured by a ratio of the thickness of the septal wall to the posterior left ventricular wall of 1:1.3; and/or
- Renal dysfunction measured by blood urea greater than 15mmol/l and serum creatinine greater than 200mmol/lGrade 4 retinopathy.

combined with an elevated blood pressure with a diastolic reading i.e. pressure in the left ventricle during the resting phase greater than 110mmHg on *optimal therapy*.

*For the purposes of this *plan* a stroke is an acute event, requiring admission to hospital, as diagnosed by a Consultant Neurologist or stroke physician. There must be *residual deficit* with a Modified Rankin Scale of 2 or above.

Surgery for Cardiac Arrhythmia

The surgical or endovascular division or ablation of abnormal conduction pathways to correct an abnormal rhythm of the heart. The abnormal rhythm of the heart must have been documented on electrocardiograph (ECG) and be available to *us*.

Surgery to correct Carotid Artery Stenosis

Therapeutic correction by open surgical techniques with endarterectomy or bypass of symptomatic stenosis of the carotid artery.

For the above definition the following are excluded:

- Surgery using intravascular techniques.

Surgical repair of an Atrial or Ventricular Septal Defect

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

Surgical repair of a Structural Abnormality of the Heart

The undergoing of, or inclusion on the NHS waiting list for, surgery undergoing of 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; and*
- 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; and
- 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; and
- 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; and
- *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; and
- Surgery to correct Carotid Artery Stenosis.

Severity Level F:

- Angioplasty (Coronary) or PTCA (Percutaneous Transluminal Coronary Angioplasty) with or without stent;
- Angioplasty to correct Carotid Artery Stenosis;
- *Permanent* Pacemaker Insertion;
- *Permanent* Defibrillator Insertion;
- Surgery for Cardiac Arrhythmia;
- Infective Endocarditis;
- Surgical Repair of an Atrial or Ventricular Septal Defect;

- Cardioversion for Cardiac Arrhythmia; and
- Emergency Intravenous Anti-arrhythmic therapy for Ventricular Tachycardia or Fibrillation.

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. 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; and
- 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;
- Angina;
- Alcoholic Cardiomyopathy;
- Only one procedure is covered for transplants of the heart and/or lungs by the *plan* regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs;
- Any second claim at any time under any of the Severity Level F procedures listed in 1 B) 2 above;
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity;
- Any cause of claim stated in section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- Any exclusion applied specifically to *your plan*.

1.c Stroke and Nervous System category– specified conditions of defined severity

1. Definitions

Alzheimer's disease

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

For the above definition, the following are not covered:

- Other types of dementia.

Alzheimer's Disease - resulting in permanent symptoms

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember;
- Reason;
- Perceive, understand, express and give effect to ideas.

For the above definition, the following are not covered:

- Other types of dementia.

Bacterial Meningitis

Confirmation by a Consultant Physician of a definite diagnosis of Bacterial Meningitis supported by cerebrospinal fluid changes consistent with bacterial meningitis. All other forms of meningitis, including viral, are not covered.

Bacterial Meningitis – resulting in permanent symptoms

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

Bilateral Hemianopia

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

Brain and Spinal tumours

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

For the above definition, the following are not covered:

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

Brain and Spinal tumours – of specified severity

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

For the above definition, the following are not covered:

- Tumours in the pituitary gland;
- Tumours originating from bone tissue; and
- 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; and
- Traumatic Brain Injury.

For the above definition, the following are not covered:

- Burr Holes procedures;
- Insertion of deep brain stimulators.

Craniotomy to treat a Cerebral Arteriovenous Malformation

The undergoing of, or inclusion on the NHS waiting list for, surgical treatment via craniotomy by a Consultant Neurosurgeon of a cerebral AV fistula or aneurysm.

Creutzfeldt-Jakob Disease

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

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

Creutzfeldt-Jakob Disease - resulting in permanent symptoms

A definite diagnosis of Creutzfeldt-Jakob disease by a Consultant Neurologist, Psychiatrist or Geriatrician. This must have been reported to the National CJD Monitoring Unit as a confirmed case. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember;
- Reason; and
- Perceive, understand, express and give effect to ideas.

Dementia

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

Dementia - resulting in permanent symptoms

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember;
- Reason; and
- Perceive, understand, express and give effect to ideas

Devic's Disease (Neuromyolitis Optica)

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

Drainage of Brain Abscess by Craniotomy

The surgical drainage of an intracerebral abscess within the brain tissue through a craniotomy by a Consultant Neurosurgeon. There must be evidence of an intracerebral abscess on CT or MRI imaging.

Encephalitis

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

Encephalitis – resulting in permanent symptoms

A definite diagnosis of Encephalitis by a Consultant Neurologist, resulting in *permanent neurological deficit with persisting clinical symptoms*.

Endovascular Treatment of a Cerebral Arteriovenous Malformation

The undergoing of, or inclusion on the NHS waiting list for, endovascular treatment by a Consultant Neurosurgeon or Radiologist using coils to cause thrombosis of a cerebral AV fistula or aneurysm.

Functional Surgery for Movement Disorders

Undergoing of surgery, in the form of deep brain stimulation, to treat tremor, parkinsonism, dyskinesia, or dystonia.

Guillain-Barré Syndrome

A definite diagnosis of Guillain-Barré Syndrome by a Neurologist, confirmed by electromyography and lumbar puncture. There must be evidence of continual and *permanent* weakness or numbness being present for a minimum period of at least 6 months, which is supported by appropriate neurological evidence.

Guillain-Barré Syndrome – of specified severity

A definite diagnosis of Guillain-Barré Syndrome by a 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); and
- Spinal muscular atrophy (SMA).

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

Multiple Sclerosis

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

Muscular Dystrophy

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

Myasthenia Gravis

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

For the above definition, the following is not covered:

- Myasthenia gravis limited to eye muscles only.

Neurological Diseases

For the purpose of this *plan* this includes any *permanent irreversible* disease affecting the basal ganglia, cerebellum, neurones, horn cells or myelin sheaths that produce identifiable *permanent* neurological deficit. If the disease, disability or symptom is not defined as a named condition in this 1 C) 1, *benefits* will be paid only when there is an inability to perform the *functional activity tests* see section 3.1. *Alcohol or drug abuse* is excluded.

Paralysis of a limb

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

Paralysis of limbs

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

Parkinson's Disease

A definite diagnosis of Parkinson's disease by a Consultant Neurologist with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

For the above definition, the following is not covered:

- Parkinsonian syndromes/Parkinsonism.

Parkinson's Disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a Consultant Neurologist.

There must be *permanent* clinical impairment of motor function with associated tremor and muscle rigidity.

For the above definition, the following is not covered:

- Parkinsonian syndromes/Parkinsonism.

Parkinson's plus syndromes

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

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

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

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

For the above definition, the following are not covered:

- Other Parkinsonian syndromes; and
- 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; or
- The lack of any purposeful movements

This condition must be *permanent* and supported by appropriate neurological evidence.

Progressive Supra-nuclear Palsy

Confirmation by a Consultant Neurologist of a definite diagnosis of Progressive Supra-nuclear Palsy with evidence of current or previous symptoms (these symptoms do not need to be *permanent*).

Progressive Supra-nuclear Palsy – resulting in permanent symptoms

Confirmation by a Consultant Neurologist of a definite diagnosis of Progressive Supranuclear Palsy. There must be *permanent* clinical impairment of motor function.

Shunt Insertion for Hydrocephalus

Surgical insertion of a *permanent* drainage shunt for the treatment of hydrocephalus. There must be enlargement of the ventricles which has been confirmed by a radiologist.

Spinal aneurysm or arteriovenous malformation

The undergoing of surgical resection, wrapping, clipping or embolisation of a spinal aneurysm or arteriovenous malformation.

Spinal Stroke

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

Stereotactic Brain Surgery

The undergoing of, or inclusion on the NHS waiting list for, the stereotactic surgery to the brain performed by a Consultant Neurosurgeon for neurological disease. Biopsy of brain tissue is specifically excluded.

Stroke

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that results in persisting *clinical symptoms* lasting for at least 24 hours. For the above definition, the following are not covered:

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

Surgery for Drug Resistant Epilepsy

Undergoing of surgery to brain tissue in order to control epilepsy that cannot be controlled by oral medication.

Surgical Repair of Depressed Skull Fracture

Undergoing surgery to correct a depression in the skull as a result of an accidental traumatic fracture or break in the cranial bone.

Syringomyelia or syringobulbia

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

Traumatic Brain Injury - with clinical symptoms

Death of brain tissue due to traumatic injury resulting in *clinical symptoms* that have persisted for a continuous period of at least 2 weeks (these symptoms do not need to be *permanent*).

For the above definition the following is not covered:

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

Traumatic Brain Injury – resulting in permanent symptoms

Death of brain tissue due to traumatic injury resulting in *permanent neurological deficit with persisting clinical symptoms*.

2. Severity levels

How is severity measured?

Modified Rankin Scale:

Severity of a stroke is measured by the Modified Rankin Scale (van Swieten et al., 1988). This is an internationally accepted measure of disability for neurological conditions, especially stroke. It is scored from 0 to 5, with 5 being the most severe. The assessment must be supervised by a Consultant Neurologist.

Functional Activity Tests (FATs):

For neurological diseases (including those not specifically stated under this *benefit*) *we* will pay a *benefit* if *you* become *permanently* unable to perform certain *functional activity tests* due to the disease.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in section 3.1.

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 section 3.1.
- Loss of Speech;
- Paralysis of limbs;
- Loss of Manual Dexterity;
- Loss of muscle power resulting in the inability to grip; and
- 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 section 3.1;
- Bilateral Hemianopia;
- Guillain-Barré Syndrome - of specified severity; and
- 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 section 3.1; and
- Surgery for Drug Resistant Epilepsy.

Severity Level D:

- Alzheimer's disease – resulting in *permanent* symptoms*;
- Bacterial Meningitis – resulting in *permanent* symptoms;
- Brain and Spinal tumours - of specified severity;
- Brain Injury due to anoxia or hypoxia;
- Coma;
- Craniotomy;
- Craniotomy to treat a Cerebral Arteriovenous Malformation;
- Creutzfeldt-Jakob Disease – resulting in *permanent* symptoms*;
- Devic's Disease (Neuromyolitis Optica);

- Dementia – resulting in *permanent* symptoms*;
- Drainage of Brain Abscess by Craniotomy;
- Encephalitis - resulting in *permanent* symptoms*;
- Functional Surgery for Movement Disorders;
- Motor Neurone Disease*;
- Multiple Sclerosis*;
- Muscular Dystrophy*;
- Parkinson's Disease – resulting in *permanent* symptoms*;
- Parkinson's plus syndromes*;
- Progressive Supra-nuclear Palsy – resulting in *permanent* symptoms*;
- Shunt Insertion for Hydrocephalus (restricted to one payment only);
- Spinal Stroke;
- Stroke*;
- Syringomyelia or syringobulbia; and
- 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 section 1.7.

Severity Level E:

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

Severity Level F:

- Alzheimer's Disease;
- Bacterial Meningitis;
- Brain and Spinal tumours;
- Creutzfeldt-Jakob Disease;
- Dementia;
- Encephalitis;
- Parkinson's Disease;
- Progressive Supra-nuclear Palsy;
- Stereotactic Brain Surgery; and
- Traumatic Brain Injury - with *clinical symptoms.*

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. 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; and*
- Loss of neurological function compatible with area of damage of the brain involved.

4. Specific exclusions

- Any condition stated in 1C) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner;
- Chronic Fatigue Syndrome, or any synonym including, but not limited to, Epidemic Neuromyasthenia, Myalgic Encephalomyelitis, Post Viral Fatigue Syndrome or Royal Free Disease;
- Pituitary tumours – specified treatments are covered within the Endocrine *benefit;*
- Transient Ischaemic Attacks;
- Benign intracranial hypertension;
- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity
- Any cause of claim stated in section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- 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; and
- 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; and
- Periportal or septal fibrosis on liver biopsy. Causes of this condition can include chronic Hepatitis B or C or Autoimmune Disease.

Chronic Pancreatitis

Chronic Inflammation of the pancreas with calcification throughout the body and tail of the gland. There must also be all of the following:

- Proof of calcification on CT scan;
- Evidence of failure of secretion of pancreatic enzymes; and
- Evidence of chronic inflammation on Endoscopic Retrograde Cholangiopancreatography (ERCP) or Magnetic Resonance Cholepancreatography (MRCP)

Cirrhosis of the Liver

A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy.

Fulminant Hepatic Necrosis

Massive necrosis (death of liver tissue) with clotting deficiencies and metabolic abnormalities which cause coma occurring in an individual without any previous liver disease. There must be jaundice, encephalopathy and admission to a specialist liver unit.

Loss of the use of more than one third of the tongue

Loss of the use of more than one third of the tongue through loss of motor function, traumatic amputation or through surgery.

Moderately Severe Inflammatory Crohn's Disease or Ulcerative Colitis

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

Partial Hepatectomy

The surgical excision of at least 25% of the liver mass by laparotomy. Liver biopsy and donation are specifically excluded.

Permanent Faecal Incontinence to age 70

There must be *permanent* incontinence of faeces with constant soiling, despite *optimal therapy* for a period of one year. This must require daily pads as prescribed by a consultant physician or surgeon.

Permanent Rectal Fistula

A *permanent* abnormal tract or connection between the rectum and the skin, bladder or vagina due to a disease of the rectum. There must be radiological evidence of the abnormal tract or connection. Fistula in ano is specifically excluded.

Portal Vein Thrombosis

The thrombosis of the portal vein causing ascites and enlargement of the spleen. There must be radiological evidence of the blockage to the portal vein as well as proof of oesophageal varices as a complication.

Sclerosing Cholangitis

An inflammation of the bile ducts proven on cholangiography, with abnormal liver function tests. There must be diagnostic appearances with irregular stricturing and dilatation on Endoscopic Retrograde Cholangiopancreatography (ERCP) or Magnetic Resonance Cholepancreatography (MRCP).

Severe Cirrhosis of the Liver

A widespread disruption of the normal architecture of the liver cells with fibrosis bridging between portal areas or between the portal area and the portal vein. There must be evidence of nodules of regenerated liver cells and the typical fibrosis pattern on liver biopsy. To be considered as severe the following must be present for at least one year and there must be all of the following throughout this period:

- Persistent jaundice marked by elevated bilirubin levels above 50 micromols/ litres;
- Abnormal protein production marked by decreased albumin levels below 27 G/L; and
- Abnormal clotting of the blood marked by a Prothrombin time above two times the normal limit or an International Normalisation Ratio (INR) test above 2.0.

Severe 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; and
- There have been 2 hospital admissions to treat this condition in the 12 months prior to claim.

For the above definition, the following are not covered:

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

Severe Inflammatory Crohn's Disease

A definite diagnosis of Crohn's Disease by a Consultant Gastroenterologist. To be considered as severe, symptoms must not have responded to *optimal therapy* while under the continued supervision of a Gastroenterologist.

There must also be evidence of continued inflammation with all of the following having occurred:

- Stricture formation causing intestinal obstruction requiring admission to hospital;
- Fistula formation between loops of bowel or bowel to another organ; and
- At least one resection of a segment of small bowel.

Surgical Repair of a Tracheo-Oesophogeal Fistula

The undergoing of, or inclusion on the NHS waiting list for, the surgical repair of an abnormal tract between the trachea and oesophagus as demonstrated by radiological methods.

Total Colectomy

Removal of the whole of the colon creating an opening on the abdomen joining the small intestine to the abdomen wall called an Ileostomy. This procedure is covered if it is established that the ileostomy is *permanent* in the opinion of both a Consultant Gastroenterologist and *our* Chief Medical Officer.

2. Severity levels

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

Severity Level A:

- Fulminant Hepatic Necrosis;
- *Permanent* Faecal Incontinence; and
- Severe Cirrhosis of the Liver.

Severity Level C:

- Sclerosing Cholangitis;
- Severe Gastrointestinal Disease - requiring hospitalisation; and
- Severe Inflammatory Crohn's Disease.

Severity Level D:

- Bowel Ischaemia requiring surgery;
- Chronic Pancreatitis; and
- Total Colectomy.

Severity Level E:

- Cirrhosis of the Liver;
- Chronic Inflammatory Hepatitis;
- Partial Hepatectomy;
- Portal Vein Thrombosis;
- Loss of use of more than one third of the Tongue.

Severity Level F:

- Surgical Repair of a Tracheo-Oesophageal Fistula;
- *Permanent* Rectal Fistula; and
- Moderately Severe Inflammatory Crohn's Disease or Ulcerative Colitis

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. Appropriate signs and symptoms compatible with the condition claimed

- Diagnosis and treatment by an *appropriate medical specialist; and*
- 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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- Any exclusion applied specifically to *your plan*.

1.e Connective Tissue Diseases category – specified conditions of defined severity

1. Definitions

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

Giant Cell Arteritis

The definite diagnosis of Giant Cell Arteritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Pemphigus Vulgaris

A chronic, relapsing autoimmune skin disease that causes blisters and erosions of the skin and mucous membranes. For the purpose of this *plan* only Pemphigus Vulgaris is covered, with the diagnosis supported by a biopsy and presence of PV auto-antibodies in the blood.

Polyarteritis Nodosa

The definite diagnosis of Polyarteritis Nodosa by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Polymyositis

Polymyositis is an inflammatory disease affecting the muscles of the limbs especially the larger muscles. For the purpose of this illness category there must be all of the following:

- Elevated serum muscle enzymes (CK, aldolase);
- Electromyographic findings typical of dermatomyositis (DM) or polymyositis (PM);
- Muscle biopsy findings typical of PM or DM (as defined immediately above); and
- Compatible weakness – symmetrical proximal muscle weakness for which there is no other explanation.

Rheumatoid Arthritis

The definite diagnosis of Rheumatoid Arthritis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Systemic Lupus Erythematosis (SLE)

The definite diagnosis of Systemic Lupus Erythematosis (SLE) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Systemic Sclerosis (Scleroderma)

The definite diagnosis of Systemic Sclerosis (Scleroderma) by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rheumatic Diseases.

Wegener's Granulomatosis

The definite diagnosis of Wegener's Granulomatosis by a Consultant Rheumatologist on the basis of the American College of Rheumatology Criteria for Classification of Rhematic Diseases.

2. Severity levels

How is severity measured? Connective Tissue Diseases:

Connective tissue diseases are a group of autoimmune diseases, which means that the body attacks itself, especially joints, blood vessels, kidneys, lungs and other organs. For the purposes of this *plan* the severity of Connective Tissue Diseases will be determined by the *permanent* inability to perform a number of *functional activity tests* (FATs). The inability to perform FATs has to be a new failure brought about by a condition that started after the start of the *plan*.

Further details of these *functional activity tests*, including which tests may apply to *you*, are provided in section 3.1.

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 section 3.1.

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 section 3.1.

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 section 3.1.

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 section 3.1.

Severity Level F:

- A definite diagnosis of giant cell arteritis, polyarteritis nodosa, polymyositis, rheumatoid arthritis, systemic lupus erythematosis, systemic sclerosis (scleroderma) or Wegener's granulomatosis; and
- Pemphigus Vulgaris.

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. 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; and
- 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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- Any exclusion applied specifically to *your plan*.

1.f Urogenital Tract and Kidney category – specified conditions of defined severity

1. Definitions

Acute Renal Dialysis

Undergoing more than two treatments of haemodialysis over a three week period or a cumulative total of more than 24 hours haemofiltration due to a rapid decline of renal function leading to renal failure.

Bilateral Orchidectomy

The undergoing of, or inclusion on the NHS waiting list for, the therapeutic surgical removal of all of both testicles due to trauma or for the treatment of a disease of the testicles or of the blood vessels supplying the testicles.

Bladder Fistula

The abnormal connection or tract between the bladder and the skin, vagina or rectum due to disease of the bladder. This must be proven by radiological evidence.

Chronic Renal Impairment

The impairment in kidney function such that the estimated glomerular filtration rate is below 25 mls/litre/ min/1.73 m2 surface area persistently for a period of six months or more.

Cystectomy

The surgical removal of the complete organ of the bladder with the construction of a urostomy or nephrostomies to allow urine to be collected external to the body. If the surgical removal is due to cancer of the bladder, only one claim can be made for whichever of the conditions is placed at the highest severity level, see 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 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 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 1 F) 2 below. Biopsy is excluded.

Severe Chronic Renal Impairment

The impairment in renal function such that the estimated glomerular filtration rate is below 15 mls/ litre/ min/1.73 m2 surface area persistently for a period of six months or more.

Surgical Repair of a Kidney

Surgical repair of acute damage to the kidney as a result of trauma. Keyhole surgery, including laparoscopic surgery, is specifically excluded.

2. Severity levels

How is severity measured? Renal function:

Severity is measured by the estimated glomerular filtration rate. This is a measure of the efficiency of the kidneys as a filter. The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Kidney Failure.

Severity Level B:

- Severe Chronic Renal Impairment.

Severity Level C:

- Chronic Renal Impairment;
- Cystectomy.

Severity Level D:

- Acute Renal Dialysis;
- Nephrectomy;
- Partial Cystectomy.
- **Severity Level E:**
- Partial Nephrectomy;
- Bilateral Orchidectomy;
- Surgical repair of a Kidney.

Severity Level F:

- Bladder Fistula.

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. 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; and
- 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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- 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; and
- Aspergilosis.

These fibrotic lung diseases produce thickening and fibrosis of the finest membranes in the alveoli that allow transfer of oxygen into the blood stream.

There must be radiological evidence of fibrosis and there must be a *permanent* and *irreversible* restriction of Vital Capacity (VC), the maximum total volume of air that can be expelled from the lung after maximum inhalation, to below 75% of predicted. There must also be a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 55% of predicted or less.

These tests must be performed under the direction of a specialist respiratory physician whilst on *optimal therapy*. They must be measured in a respiratory laboratory, which has regular quality control audits available to us, and be supervised by the treating specialist. When both chronic obstructive pulmonary disease and fibrotic lung disease co-exist, only one payment will be made (for the condition which is at the highest severity level).

Home Oxygen Therapy

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

Mechanical Ventilatory Support for Near Drowning

Mechanical ventilatory support for at least 24 hours following full resuscitation as a consequence of near drowning.

Pleurectomy

The therapeutic surgical excision of the pleura (the membrane covering the lungs) for documented disease.

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

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

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

Pulmonary Embolus

The blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs) or an angiography.

Removal of One Lobe of the Lungs

The undergoing of, or inclusion on the NHS waiting list for, the therapeutic surgical removal of one lobe of the lungs for documented disease or trauma.

Removal of Two or more Lobes of the Lungs

The undergoing of, or inclusion on the NHS waiting list for, the therapeutic surgical removal of two or more lobes of the lungs for documented disease or trauma.

Surgical Drainage of a Lung Abscess

The surgical drainage of an abscess in the parenchyma of the lung using a thoracotomy.

Surgical Drainage of Empyema

The collection of pus in the pleural space. This is the space between the lung and the ribcage. The empyema must have been drained using a thoracotomy operation to qualify for this *benefit*.

2. Severity levels

How is severity measured?

Chronic Obstructive Pulmonary Disease:

Severity is assessed by the measurement of:

1. Vital Capacity (VC). This is the maximum total volume of air that can be expelled from the lung after maximum inhalation.
2. The Forced Expiratory Volume 1 (FEV1). The maximum volume of air expelled in one second.
3. The ratio of the two measurements.

Fibrotic Lung Disease:

The severity is measured by the Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco), that is the measurement that reflects the transfer of gases across the membranes of the lung into the blood stream from the air. This can only be performed in a lung function laboratory. It is called the transfer factor. The amount of the claim depends on the severity of the illness *you* suffer.

The following levels apply:

Severity Level A:

- Fibrotic Lung disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of 34% of predicted or less;
- Home Oxygen Therapy;
- Cor Pulmonale; andPulmonary 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; and
- 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; and
- Removal of one lobe of the lungs.

Severity Level E:

- Surgical Drainage of a Lung Abscess;
- Surgical Drainage of Empyema;
- Pleurectomy; and
- Pulmonary Embolus

Severity Level F:

- Mechanical Ventilatory Support for Near Drowning; and
- Fibrotic Lung Disease with a Transfer Factor (or Diffusing Capacity) for carbon monoxide (Dco) of between 50% and 55% of predicted.

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. 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; and
- 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 lung;
- 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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- 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; and*
- 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; and
- 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; and*
- An organ transplan.

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1and 3.

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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- Any exclusion applied specifically to *your plan*.

1.i Musculoskeletal Trauma category – specified conditions of defined severity

1. Definitions

Amputation of Two or More Fingers or Thumbs

Permanent physical severance of two or more fingers or thumbs at the metacarpal bone.

Intensive care for 10 days continuous duration

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

For the above definition the following are not covered:

- *Children* under the age of 30 days; and
- Sickness or injury as a result of *alcohol and drug abuse* 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; and
- Surgery to re-attach a limb following amputation at or above the wrist or ankle joint.

Extensive Skin Burns

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

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

2. Severity levels

How is severity measured?

Extensive Skin Burns:

Severity is measured from the Wallace 'rule of nine' which is the most common method for determining burn percentage. This method divides the body surface into areas each representing nine per cent of total body surface area. Adding up the injured areas provides an assessment of burn percentage.

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

Severity Level A:

- Extensive Skin Burns;
- Loss of hands or feet;

Severity Level B:

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

Severity Level C:

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

Severity Level D:

- Surgical Re-attachment of an Amputated Limb.

Severity Level E:

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

Severity Level F:

- Amputation of two or more fingers or thumbs at the metacarpal bon.

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. 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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- 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

Corneal Transplant

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

For the above definition, the following are not covered:

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

Severe Visual Impairment

Permanent and *irreversible* reduction in the sight of both eyes such that the Snellen rating is less than 6/36 after correction.

Significant Visual Impairment

Permanent and *irreversible* reduction in the sight of both eyes such that the Snellen rating is less than 6/18 after correction.

Surgical Removal of one eye

Surgical removal of a complete eyeball for disease or trauma.

Surgical Repair of a Detached Retina

The surgical repair of a detached retina by a Consultant Ophthalmologist. Laser surgery is specifically excluded.

Tunnel Vision

Permanent and *irreversible* loss of peripheral vision such that the total field of vision is 90 degrees or less in the horizontal plane with both eyes open. The measurement of this must be supervised by a Consultant Ophthalmologist.

2. Severity levels

How is severity measured?

Visual acuity:

The Snellen rating is the measurement of visual acuity using a standard Snellen chart at 6 metres. This must be supervised by a Consultant Ophthalmologist and reported as a fraction such as 6/18 or 6/36, meaning an individual can read at 6 metres letters that people with normal vision can read at 18 or 36 metres.

The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Blindness;
- Severe Visual Impairment;

Severity Level C:

- Significant Visual Impairment;
- **Severity Level D:**
- Central Blindness;

Severity Level E:

- Blindness in one Eye;
- Central Retinal Occlusion;
- Tunnel Vision;
- Surgical Removal of one Eye;

Severity Level F:

- Corneal Transplant;
- Surgical repair of a detached retina.

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. 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; and
- 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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- Any exclusion applied specifically to *your plan*.

1.k Ear to Age 70 category – specified conditions of defined severity

1. Definitions

Deafness

Permanent and *irreversible* loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

Radical Mastoid Surgery

The surgical drainage and excision of chronically infected bony tissue from the mastoid area of the skull. There must have been radiological proof of bony destruction of the mastoid bones by infection.

Significant Hearing Loss in Both Ears

Permanent and *irreversible* loss of hearing to the extent that the loss is greater than 70 decibels across all frequencies in the better ear using a pure tone audiogram. There should be at least two measurements over a period of six months in order for a claim to be considered.

2. Severity levels

How is severity measured? Hearing loss:

Severity is measured according to the latest version of the British Society of Audiology guidelines for Audiometry. The amount of the claim depends on the severity of the illness *you* suffer. The following levels apply:

Severity Level A:

- Deafness;

Severity Level C:

- Significant hearing loss in both ears;

Severity Level F:

- Radical Mastoid Surgery.

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. 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; and*
- 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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- Any exclusion applied specifically to *your plan.*

1.l Endocrine and Metabolic Diseases category – specified conditions of defined severity

1. Definitions

The following conditions are covered (only one payment will be made for each):

Acromegaly

A disease of the pituitary gland with production of excess growth hormone which cannot be suppressed below 2 ng/ml after a 75 Gram oral glucose load.

Addison's Disease

Primary Adrenal insufficiency is a disease in an individual who has never taken steroids without pituitary disease. There must be low levels of circulating steroids and high levels of Adrenocorticotrophic hormone. This must be present for at least six months.

Adrenalectomy

The therapeutic surgical removal of the complete adrenal gland for documented disease.

Conn's Syndrome

A disease of the adrenal glands with persistently raised aldosterone levels and reduced rennin levels. There must be evidence of low serum levels of potassium of less than 3 Mmol/L, rennin levels of less than 1ng/ml/ Hr and a plasma aldosterone level of greater than 15 nG/dl.

Cushing's Syndrome

A disease in an individual who has never taken steroids with raised cortisol on 24 hour urine collection and confirmatory testing such as dexamethasone test or imaging of the adrenal and/or pituitary glands. This must be present for at least six months.

Diabetes Insipidus

The *permanent* inability of the body to concentrate urine. This must be *permanent* and be caused by either the lack of the hormone vasopressin to be secreted or the failure of the kidney to respond to vasopressin. This is not Diabetes Mellitus (Sugar Diabetes).

Insulin dependent Diabetes Mellitus (Type I)

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

For the above definition, the following are not covered:

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

Insulinoma

A tumour of the pancreas producing high levels of insulin causing recurrent attacks of hypoglycaemia. The insulinoma must be diagnosed by MRI or CT scan.

Pheochromocytoma

A tumour of the adrenal gland producing high levels of adrenal hormones. The secretion can be demonstrated by high levels of urinary vanillyl mandelic acid and is associated with a compatible complication such as raised blood pressure.

Radiotherapy to the Pituitary Gland

Radiotherapy to the pituitary gland for the treatment of a documented pituitary adenoma.

Sheehan's Syndrome

Evidenced by radiological evidence of infarction of the pituitary gland, a serum prolactin of less than 5 ng per ml and evidence of failure of the pituitary to secrete other hormones.

Simmond's Disease

An *irreversible* failure of the pituitary to secrete normal levels of hormones. There must be all of the following: low T4 hormone levels, low T3 resin uptake, low testosterone levels and low prolactin levels. These must be present for at least six months and require replacement therapy.

Surgical Removal of the Pituitary Gland

The surgical removal of the pituitary gland for the treatment of a documented pituitary adenoma.

Thyrotoxic Crisis

A clinical condition in someone who has never taken thyroid hormones, with fever, rapid heart rate of over 130, delirium and coma. These symptoms must result in admission to hospital for at least seven days. There must be recorded levels of circulating thyroid hormones at least three times the normal level.

2. Severity levels

The amount of the claim depends upon the severity of the illness *you* suffer. The following levels apply.

Severity Level E:

- Diabetes Insipidus;
- Insulin dependent Diabetes Mellitus (Type 1);
- Sheehan's Syndrome;
- Thyrotoxic Crisis;

Severity Level F:

- Conn's Syndrome;
- Cushing's Syndrome;
- Addison's Disease;
- Pheochromocytoma;
- Surgical Removal of the Pituitary Gland;
- Radiotherapy to the Pituitary Gland;
- Insulinoma;
- Simmond's Disease;
- Adrenalectomy; and
- Acromegaly.

3. Evidence required in the event of a claim

This should be read in addition to and in connection with section 1.1 and 3. Any or all of the following may apply to any claim under this category:

- Relevant signs and symptoms must be present compatible with the condition claimed
- Investigations must be available
- Diagnosis and treatment must be by an *appropriate medical specialist*

4. Specific exclusions

- Any claim for Non-Insulin dependent Diabetes Mellitus (Sugar Diabetes);
- Any second claim at any time under any of the illnesses listed above in 1L;
- 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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition;and
- Any exclusion applied specifically to *your plan*.

1.m Major Organ Transplant category

1. Definitions

Major Organ Transplant

The undergoing as a recipient of a transplant of bone marrow; or of a complete heart, kidney, liver, lung, pancreas; or of a lobe of lung or liver from another donor; or inclusion on an official *UK* waiting list for such a procedure. For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

Only one procedure is covered for transplants of the heart and/or both lungs by the plan regardless of whether the procedure is the transplant of a heart, a lung, both lungs, a heart and a lung or a heart and both lungs.

2. Severity levels

Severity Level A:

- Major Organ Transplant.

3. Evidence required in the event of a claim

This should be read in addition to *your* existing *plan* provisions and in connection with section 1.1 and 3. 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; and
- 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 section 3.2 (Exclusions);
- Any exclusion contained within the definition of any named condition; and
- 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; or

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 ever again

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

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

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

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

b) Total 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 section 3.1).

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 section 3.1).

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 section 3.1.

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 section 3.1.

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; and*
- Total *permanent* disability for *children*.

Severity Level C:

- Total *permanent* disability – unable, before age 65, to do at least two *work tasks* ever again; and
- 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 section 1.1 and 3. 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; and
- 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 1N) above where the required permanence has not been established before the cover terminates or at age 70 where stated, if sooner;
- Any diagnosis. disease. disorder, condition, procedure or disability not listed in the Definitions section of this illness category, or not meeting the stated minimum required severity;
- Any cause of claim stated in section 3.2 (Exclusions);
- Any exclusion within the definition of any named condition; and
- Any exclusion applied specifically to *your plan*.

Appendix 2.

Serious Illness Cover Booster and Mortgage Serious Illness Cover definitions.

This appendix replaces the corresponding appendix in *your* existing plan provisions. Any reference to the Illnesses and Conditions impacted by Serious Illness Cover Booster Appendix in *your* existing plan provisions will now refer to the following section.

This Appendix lists the conditions to which Serious Illness Cover Booster and Mortgage Serious Illness Cover applies. For details of the Definitions for these conditions please refer to Appendix 1.

Appendix 2.1

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

Condition

Cancer

- Advanced Hodgkin's disease, classified as Ann-Arbor Stage II,
- Advanced Non-Hodgkin's Lymphoma, classified as Ann-Arbor Stage II;
- Advanced Cancer classified as a TNM group stage II tumour;
- Cancer - excluding less advanced cases; and
- 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); and
- 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; and
- 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; and
- Loss of use of a whole hand.

Respiratory

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

Stroke and nervous systems

- Any neurological disease causing *permanent* and *irreversible* inability to perform 3 out of 6 *functional activity tests;*
- Alzheimer's disease - resulting in *permanent* symptoms;
- Bacterial Meningitis – resulting in *permanent* symptoms;
- Brain and Spinal tumours – of specified severity;
- Bilateral hemianopia;
- Coma;
- Creutzfeldt-Jakob disease - resulting in *permanent* symptoms;
- Dementia - resulting in *permanent* symptoms;
- Devic's Disease (Neuromyolitis Optica);
- Encephalitis - resulting in *permanent* symptoms;
- Guillain-Barré Syndrome – of specified severity;
- 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; and
- Traumatic Brain injury - resulting in *permanent* symptoms.

Urogenital and kidney

- Severe chronic renal impairment.

Appendix 2.2

If *your plan schedule* indicates that *you* have selected Serious Illness Cover Booster then in the event of a claim for a *serious Illness* condition listed below *we* will increase the lump sum *we* pay *you*. The increase in lump sum will depend on *your* age at the time *you* claim and the number of dependent *children* covered under Child Serious Illness Cover in this *plan*. The way the increase in lump sum is calculated is described in section 1.3. Appendix 2.2 does not apply to Mortgage Serious Illness Cover.

Condition

Connective Tissue Diseases

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

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

Eye

- Blindness;
- Severe visual impairment;

Gastrointestinal

- *Permanent* faecal incontinence;

Musculoskeletal trauma

- Loss of hands or feet;
- Extensive Skin Burns;

Permanent disability

- Cauda Equina;
- Total and *permanent* disability - unable to do at least four *tasks designed* to assess whether *you* can look after *yourself* ever again;
- Total and *permanent* disability - unable before age 65 to do at least four *work tasks* ever again;
- Mental and Behavioural disorder - persistent confusional state to age 70;
- Total and *permanent* disability - unable before age 70 to do *your own occupation* ever again;
- Mental and Behavioural disorder - total lack of social interaction to age 70.

Stroke and nervous systems

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

Appendix 3.

Later Life Options.

Appendix 3.1

1. Definitions

Advanced Alzheimer's disease

A definite diagnosis of Alzheimer's disease by a consultant neurologist, psychiatrist or geriatrician resulting in *permanent* inability to perform 2 or more Cognitive Tasks. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember;
- Reason;
- Perceive, understand, express and give effect to ideas;

For the above definition, the following are not covered:

- Other types of dementia.

Advanced Dementia

A definite diagnosis of dementia by a consultant neurologist, psychiatrist or geriatrician resulting in *permanent* inability to perform 2 or more Cognitive Tasks. There must be *permanent* clinical loss of the ability to do all of the following:

- Remember;
- Reason; and
- Perceive, understand, express and give effect to ideas.

Nursing Home Care (for at least 3 months) – of specified cause

Permanently (full time) residing in a nursing home for at least 3 months or been receiving support from a nurse or carer at home for at least 5 hours a day for at least 3 months, due to one of the following conditions:

Permanent inability to perform 4 out of 6 *activities of daily living:*

- Advanced Alzheimer's Disease with *permanent* inability to perform 4 out 6 Cognitive Tasks;
- Advanced Dementia with *permanent* inability to perform 4 out 6 Cognitive Tasks;
- Parkinson's disease resulting in the *permanent* inability to perform 4 out of 6 ADLs; and
- Stroke with a *residual deficit* measuring 4 or above on the Modified Rankin Scale.

For the purposes of this definition:

- A nursing home is defined as a residential care facility with registered nursing staff *permanently* (full time) on duty;
- A carer is defined as a trained care worker, or group of care workers, in order to assist with nursing or care needs;
- All nursing staff must be CQC trained (or equivalent).

Parkinson's disease resulting in the permanent inability to perform 2 or more out of 6 ADLs

A definite diagnosis of Parkinson's disease by a Consultant Neurologist resulting in the *permanently* (full time) inability to perform 2 or more out 6 ADLs. For the above definition, the following is not covered:

- Parkinsonian syndromes/Parkinsonism.

Permanent inability to perform activities of daily living (ADL)

The *permanent* loss of physical ability through illness or injury to do a specified number of *tasks designed to assess whether you can look after yourself* ever again.

The relevant specialist must reasonably expect that the disability will last throughout life with no prospect of improvement.

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

These specified tasks (*we* also refer to these tasks as *activities of daily living*) are:

- Washing – The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Getting dressed and undressed – The ability to put on, take-off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances;
- Getting between rooms - The ability to get from room to room on a level floor.
- Feeding yourself – The ability to feed yourself when food has been prepared and made available;
- Getting in and out of bed – The ability to get out of bed into an upright chair or wheelchair and back again. For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered; and
- Maintaining personal hygiene – The ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.

The above tasks will be assessed through standardised testing in place at the time of the claim.

Residential Home Care (for at least 3 months) – of specified cause

Permanently (full time) residing in a residential care home on a *permanent* basis for at least 3 months due to one of the following conditions:

- *Permanent i*nability to perform 4 out of 6 *activities of daily living;*
- Advanced Alzheimer's Disease with *permanent* inability to perform 4 out 6 Cognitive Tasks;
- Advanced Dementia with *permanent* inability to perform 4 out 6 Cognitive Tasks;
- Parkinson's disease resulting in the *permanent* inability to perform 4 out of 6 ADLs
- Stroke with a *residual deficit* measuring 4 or above on the Modified Rankin Scale.

For the purposes of this definition:

- A residential care home is defined as a residential care facility with trained care assistants *permanently* on duty
- All residential staff must be CQC trained (or equivalent).

Stroke with a residual deficit measuring 3 or more on the Modified Rankin Scale

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that results in persisting *clinical symptoms* lasting for at least 24 hours and measuring 3 or more or above on the Modified Rankin Scale.

For the above definition, the following are not covered:

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

2. Severity levels

How is severity measured?

To assess the severity of Advanced Alzheimer's disease and Advanced Dementia, the following cognitive tasks will be used.

Cognitive Tasks

The *permanent* loss of cognitive ability through illness or injury to do a specified number of *tasks designed to assess whether you can look after yourself ever again.*

The relevant specialist must reasonably expect that the disability will last throughout life with no prospect of improvement.

You must need the help of supervision of another person and be unable to perform the task on *your* own and having taken any appropriate prescribed medication.

The specific tasks are:

- Feeding – Demonstrate the cognitive ability to eat regular meals without being prompted;
- Washing – Demonstrate the cognitive ability to initiate appropriately without prompting, and sequence washing by any means, with the use of assistive devices where applicable;
- Dressing – Demonstrate the cognitive ability to initiate appropriately without prompting, and sequence, putting on and taking off of all necessary garments, with the use of assistive devices where applicable;
- Communication – Demonstrate the ability to present rational ideas and to reason clearly;
- Orientation - Demonstrate the cognitive ability to recognise people commonly known to *you* or to recognise when and where *you* are in time and location; and
- Continence - Demonstrate the cognitive ability to recognise, initiate and sequence the task of bowel and bladder functions such that an adequate level of personal hygiene can be maintained;

The above cognitive tasks will be assessed through standardised testing in place at the time of the claim.

Severity Level A:

- Nursing Home Care (for at least 3 months) – of specified cause;
- Residential Home Care (for at least 3 months) – of specified cause;

Severity Level B:

- *Permanent* inability to perform 4 or more *activities of daily living*;
- Stroke with a *residual deficit* measuring 4 on the Modified Rankin Scale;
- Parkinson's Disease resulting in the *permanent* inability to perform 4 out of 6 ADLs;
- Advanced Alzheimer's Disease resulting in the *permanent* inability to perform 4 out of 6 Cognitive Tasks;
- Advanced Dementia resulting in the *permanent* inability to perform 4 out of 6 Cognitive Tasks;

Severity Level C:

- *Permanent* inability to perform 3 or more *activities of daily living;*
- Parkinson's Disease resulting in the *permanent* inability to perform 3 out of 6 ADLs;
- Advanced Alzheimer's Disease resulting in the *permanent* inability to perform 3 out of 6 Cognitive Tasks;
- Advanced Dementia resulting in the *permanent* inability to perform 3 out of 6 Cognitive Tasks;

Severity Level D:

- *Permanent* inability to perform 2 or more *activities of daily living;*
- Stroke with a *residual deficit* measuring 3 on the Modified Rankin Scale;
- Parkinson's Disease resulting in the *permanent* inability to perform 2 out of 6 ADLs;
- Advanced Alzheimer's Disease resulting in the *permanent* inability to perform 2 out of 6 Cognitive Tasks;
- Advanced Dementia resulting in the *permanent* inability to perform 2 out of 6 Cognitive Tasks;

3. Evidence required in the event of a claim

This should be read in addition to and in connection with sections 2.1.3 and 3.

Any of the following may apply to any claim under this category:

- Must be diagnosed and treated by an *appropriate medical specialist*
- Relevant investigations and reports must be available
- Signs and symptoms must be compatible with the condition claimed

In order for a claim to be paid, *we* will require that the extent of permanency has been established to *our* satisfaction.

4. Specific exclusions

- Any diagnosis, disease, disorder, condition, procedure or disability not listed in the definitions section of this Appendix, or not meeting the stated minimum required severity
- Any cause of claim stated in section 3
- Any exclusion within the definition of any named condition
- *You* have already claimed for a related condition under *your* Serious Illness Cover listed in Appendix 3.2
- Any exclusion applied specifically to *your plan* during *your* Serious Illness Cover term

Appendix 3.2

- If *you* claim for the below conditions under Serious Illness Cover during the life of *your plan, you* will not be able to claim for that condition, or any related conditions, under Later Life Options.

Serious Illness Cover conditions	Related conditions under Later Life Options
• Total *permanent* disability • Any Neurological Disease causing the *permanent* and *irreversible* inability to perform two or more *functional activity tests* • Any connective tissue disease causing the *permanent* inability to perform one or more *functional activity tests* • A Stroke with a *residual deficit* measuring at least 2 on the Modified Rankin Scale	• Failure of 2 or more *activities of daily living* • Nursing Home Care – of specified cause • Residential Home Care – of specified cause • A Stroke with a *residual deficit* measuring at least 3 on the Modified Rankin Scale • Parkinson's disease resulting in the *permanent* inability to perform 2 or more out of 6 ADLs
• Alzheimer's disease – resulting in *permanent* symptoms • Alzheimer's disease • Dementia – resulting in *permanent* symptoms • Dementia • Persistent Confusional State • Parkinson's Plus syndromes	• Advanced Alzheimer's Disease • Advanced Dementia • Nursing Home Care – of specified cause • Residential Home Care – of specified cause

Appendix 4.

(I) - Subsequent claims for Serious Illness Cover.

The following appendices replaces the corresponding appendices in *your* existing *plan* provisions.

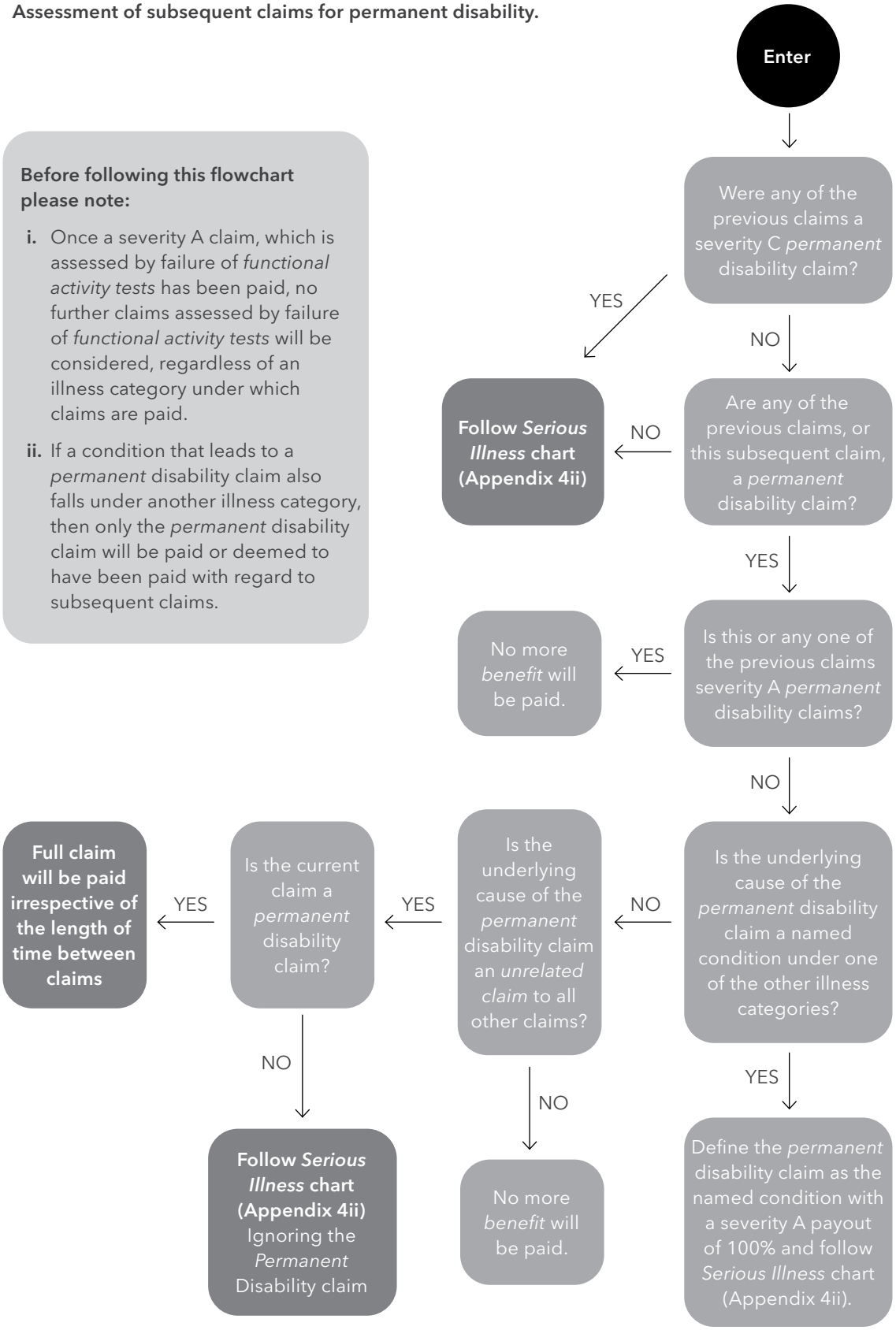
Any reference to Subsequent claims for Serious Illness Cover Appendix in *your* existing *plan* provisions will now refer to the following section.

Assessment of subsequent claims for permanent disability.

Before following this flowchart please note:

i. 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.

ii. 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.



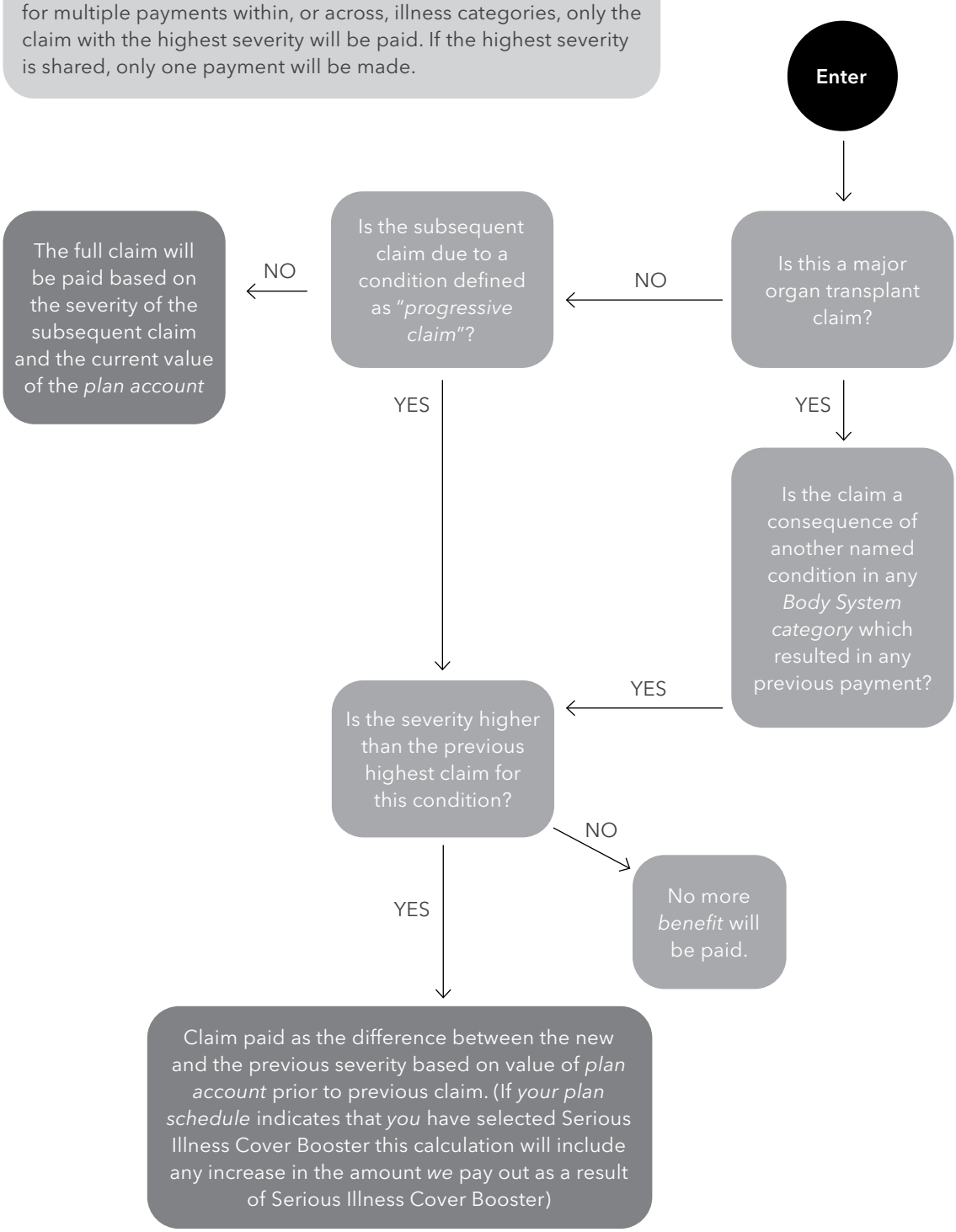
Appendix 4.

(ii) - Subsequent claims for serious illness cover.

Assessment of subsequent progressive or subsequent unrelated serious illness cover claims.

Before following this flowchart please note:

If the claim is a result of the same *life-changing event* and qualifies for multiple payments within, or across, illness categories, only the claim with the highest severity will be paid. If the highest severity is shared, only one payment will be made.

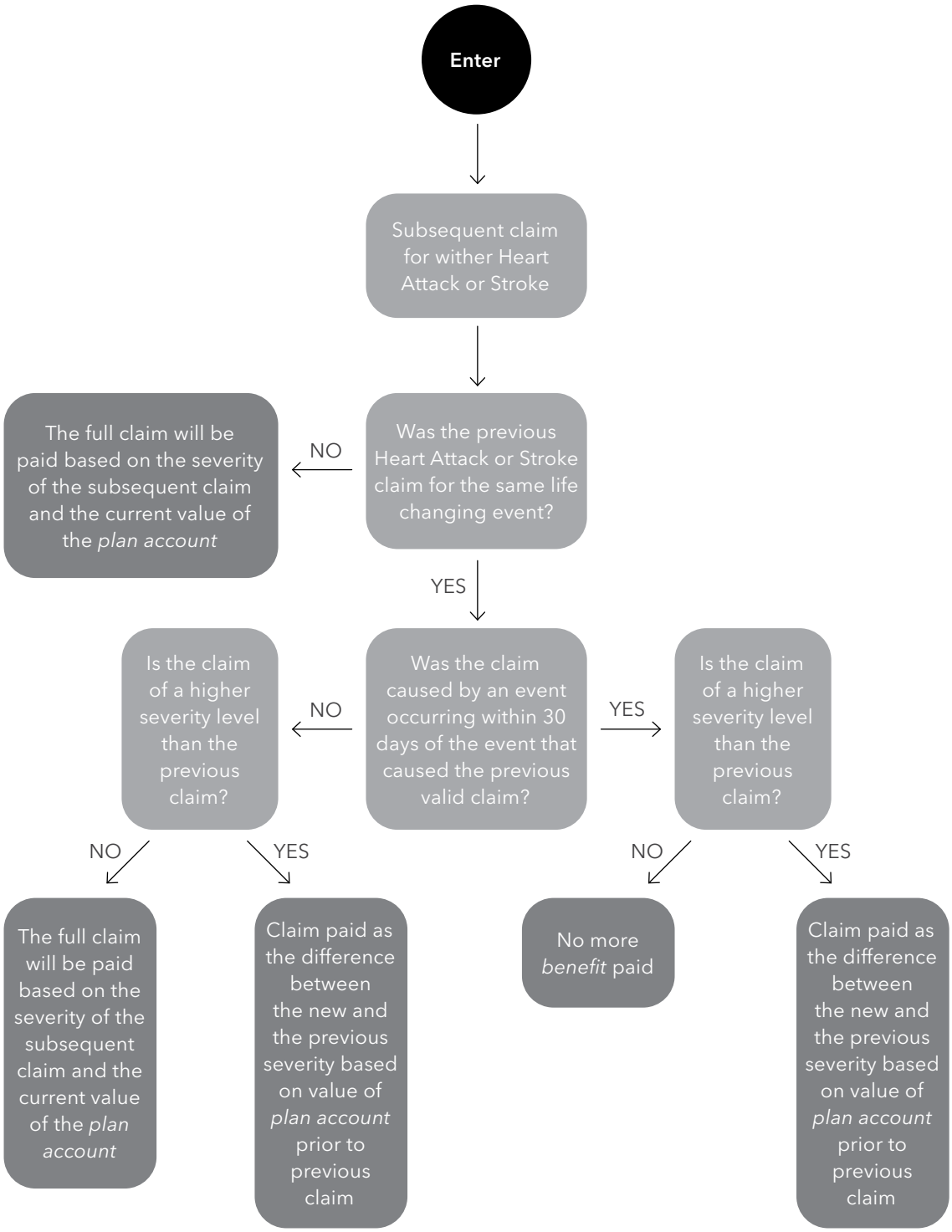


Note: this does not apply to Heart Attack and Stroke. Please refer to Appendix 4 (iii)

Appendix 4.

(iii) - Subsequent claims for serious illness cover.

Assessment of subsequent claims for Heart Attack or Stroke.

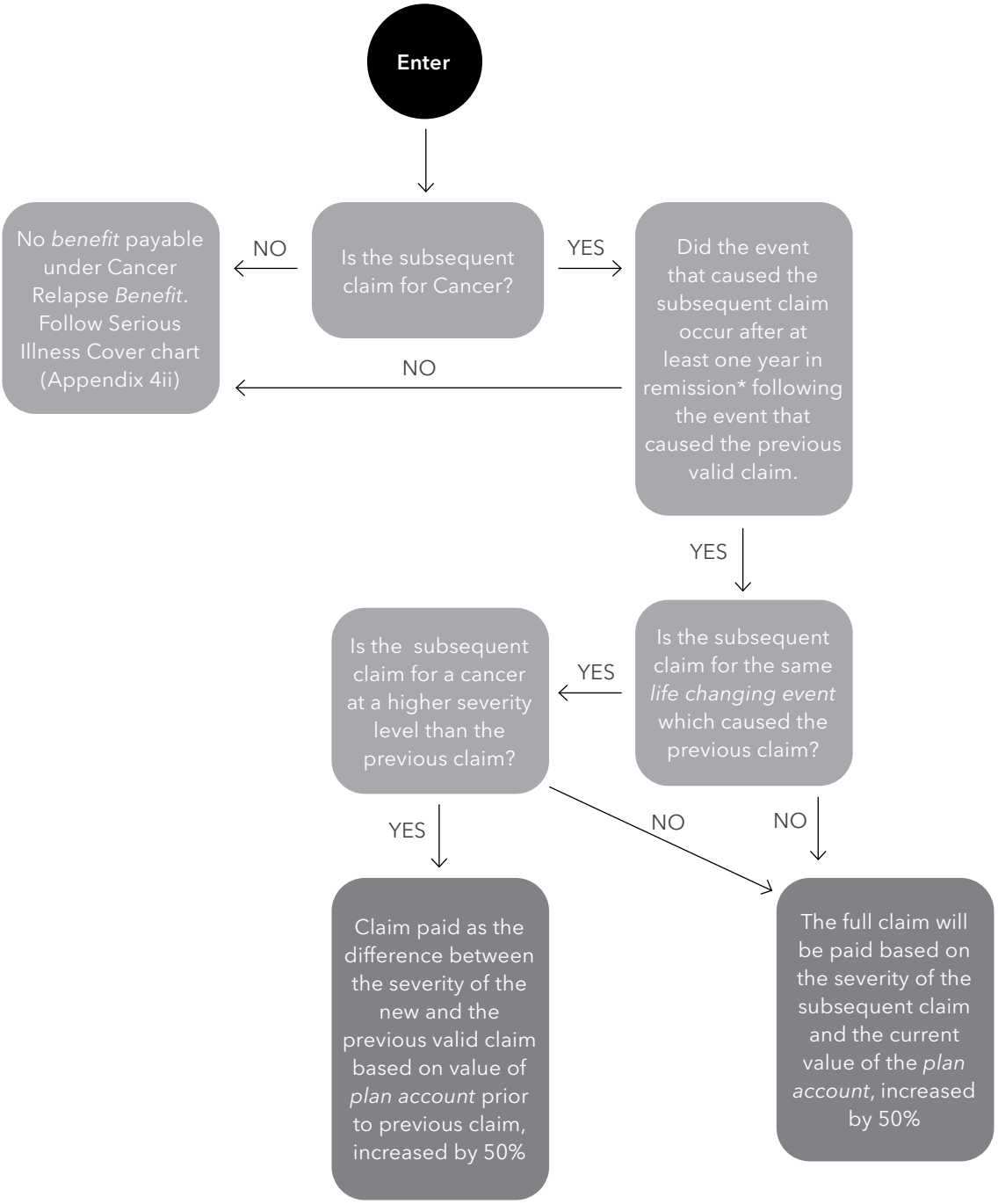


Note: Heart Attack and Stroke are treated as two different life changing events.

Appendix 4.

(iv) - Subsequent claims for cancer under Cancer Relapse Benefit.

Assessment of subsequent claims for Cancer under Cancer Relapse Benefit.



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

Find out more.

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

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