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AVIVA

Critical Illness+
Policy conditions

Keep this document safe

These **policy conditions** are written confirmation of your contract with Aviva Life & Pensions UK Limited and should be read together with your **policy schedule and policy summary**.
You may need to refer to these documents in the future if you need to make a claim.

The words in **bold** are defined terms with specific meanings. We explain these in the definitions section.

Any questions?

Call us on:

0800 285 1098

If you're outside the UK, call:

+44 1603 603 479

Lines are open Monday to Friday 8.00am-8.00pm, Saturday 8.30am-5.00pm and Sunday 10.00am-4.00pm.

Calls may be monitored and will be recorded.

Need to make a claim?

Please read our 'Making a claim' section first, then call us on:

0800 158 3467

Lines are open Monday to Friday 8.00am-6.00pm, Saturday 8.00am-2.00pm.

Calls may be monitored and will be recorded.

Your cover

You can have either a **single policy** for one person or a **joint policy** for two people, usually you and your partner, spouse or civil partner.

Main benefits

Your policy will include the **main benefits** and additional critical illness benefits.
You can find out more about these in the **main benefits** section.

You can choose from the start to receive the **main benefits** on a level, decreasing or family income basis.

	Level cover	Decreasing cover	Family income cover
How do we pay the **cover amount** if you make a successful claim?	Cash lump sum	Cash lump sum	Monthly instalments
Does the **cover amount** change over the **policy term**?	Stays the same	Decreases each month using a fixed interest rate.	The monthly instalment stays the same throughout the **policy term**. We pay it from the date we accept a claim until the policy **end date**.

If you have level or family income cover and choose the increasing cover option, your **cover amount** may go up.

The **policy conditions** we send you when you take out the policy will detail the **main benefits**. We'll show these in your **policy schedule**, together with how you've chosen to receive your **main benefits** if we accept your claim.

Optional benefits

You can choose to add optional benefits to your policy when you take it out. Your **policy schedule** will show exactly which optional benefits you've chosen. Your **policy conditions** will include details of all the optional benefits available, including any that you haven't chosen (except fracture cover and/or global treatment, which won't be included if you haven't chosen them).

Additional benefits

You may be eligible for additional benefits. If you are, they'll automatically be added to your policy, at no extra cost. Your **policy schedule** will show which additional benefits you're eligible for. All additional benefits are outlined in your **policy conditions**.

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Main benefits – Critical illness cover

We'll only pay the **main benefit** once, even for **joint policies.** This means the policy – whether single or joint – will end when we accept a claim for one of the **main benefits** listed below. The exception to this is where you've chosen extra care cover, as described below.

For **joint policies,** if one of the **lives covered** dies and was not eligible to make a claim under this policy, it can continue for the remaining **life covered.**

Critical illness benefit

Our criteria

We'll pay this if the **life covered** meets the definition for one of our critical illness conditions during the **policy term** and survives for at least 10 days.

See the full list of critical illnesses, together with our definitions for them in Appendix 1A.

Once we've accepted a claim the policy will end, unless you've chosen extra care cover and the **life covered** claiming under this critical illness benefit is eligible to claim under extra care cover benefit. See page 8 for further details of how extra care cover works.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**.

Accelerated surgery benefit

Our criteria

We'll pay this if the **life covered** is placed on an NHS waiting list for one of the surgical treatments set out below and survives for at least 10 days.

Surgical treatments:

- aorta graft surgery
- coronary artery bypass grafts
- heart valve replacement or repair
- major organ transplant
- pulmonary artery surgery
- structural heart surgery.

See our full definitions for each of these surgical treatments in Appendix 1A.

Once we've accepted a claim the policy will end, unless you've chosen extra care cover and the **life covered** claiming under this accelerated surgery benefit is eligible to claim under extra care cover benefit. See page 8 for further details of how extra care cover works.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**.

Additional critical illness benefits – Critical illness cover

Two additional benefits are automatically included: additional critical illness benefit and **children's benefit.** To be able to claim for these additional benefits, you must not have made nor be eligible to make a claim for any of the **main benefits.**

If we accept a claim for any of the additional benefits, your policy will continue. That means you can still make a claim for any of the **main benefits** later on to receive the **cover amount**. Also, it won't affect the amount of any payment we make in the future.

Additional critical illness benefit

Our criteria

We'll pay this if the **life covered** meets the definition for one of our additional critical illnesses (set out below) during the **policy term** and survives for at least 10 days.

Additional critical illnesses:

- Less advanced cancer of the breast
- Less advanced cancer of the prostate.

See our full definitions for each of the additional critical illnesses in Appendix 1B.

Each **life covered** will be able to make one claim for each additional critical illness. After which, that **life covered** won't be able to make another claim for that condition. However, we will still cover them for the other additional critical illness.

It won't affect any of the other benefits chosen under the policy for each **life covered**.

What do we pay?

We'll pay the lower of:

- £25,000, or
- 25% of the **cover amount** shown in the **policy schedule**. For family income cover, we'll multiply this figure by the number of months left on your policy and pay this as a lump sum.

If a claim meets our criteria for critical illness benefit and additional critical illness benefit at the same time, we'll only pay the **cover amount**.

Children's benefit

Our criteria

This includes children's critical illness benefit, hospital benefit and children's death benefit, as described below.

It covers any **child** under the policy.

Children are covered from the age of 30 days until their 18th birthday (or 21st birthday if in full time education). They must be between these ages at the time they:

- meet the definition for one of our children's critical illness conditions, or
- stay in hospital, or
- die.

We'll accept a claim for each of the below benefits for each **child**. The cover will continue for any other **child**.

Children's critical illness benefit

Our criteria

We'll pay this if a **child** meets the definition for one of our children's critical illnesses during the **policy term** and survives for at least 10 days.

Our children's critical illnesses are all of the critical illnesses in Appendix 1A and the additional critical illnesses in Appendix 1B.

The illness or condition must not have been present at birth, whether diagnosed or not. The symptoms must not have started before the policy **start date** or before the **child** was covered by the policy. In addition, the illness or condition must not be the result of an intentional injury caused by you.

What do we pay?

We'll pay the lower of:

- £25,000, or
- 50% of the **cover amount** shown in the **policy schedule**. For family income cover, we'll multiply this figure by the number of months left on your policy, and pay this as a lump sum.

Children's hospital benefit

Our criteria

We'll pay this if the **child** is in hospital for more than seven consecutive nights. We pay it from the eighth night's stay (not the first seven nights).

We won't pay if the stay in hospital is due to the **child** being born prematurely (before the 37th week of pregnancy).

What do we pay?

We'll pay £100 a night for a maximum of 30 nights for each **child**.

The nights spent in hospital could be over one period or a number of periods over the **policy term**.

If the **child** is admitted to hospital multiple times for the same or a related reason, they won't have to stay another seven nights before you can claim again.

Children's death benefit

Our criteria

We'll pay this if a **child** dies during the **policy term**.

What do we pay?

We'll pay £5,000.

Optional benefits – Critical illness cover

Your **policy schedule** will show any optional benefits you've chosen to add to your policy.

Upgraded critical illness benefit

If you choose to add **upgraded critical illness benefit**, to your critical illness cover, you'll receive upgraded critical illness conditions, upgraded additional critical illness benefit and upgraded accelerated surgery benefit.

Upgraded critical illness conditions

We'll cover you for upgraded critical illness conditions on top of the critical illnesses covered under your **main benefits**.

Our criteria

We'll pay this if the **life covered** meets the definition for one of our upgraded critical illness conditions during the **policy term** and survives for at least 10 days.

Our **upgraded critical illness benefit** includes all of the critical illnesses in Appendix 1A and the upgraded critical illness conditions in Appendix 2A.

Once we've accepted a claim the policy will end, unless you have chosen extra care cover and the **life covered** claiming under this upgraded critical illness benefit is eligible to claim under extra care cover benefit. See page 8 for further details of extra care cover.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**.

Upgraded additional critical illness benefit

We'll replace your additional critical illness benefit with upgraded additional critical illness benefit.

Our criteria

We'll pay this if the **life covered** meets the definition for one of our upgraded additional critical illnesses during the **policy term** and survives for at least 10 days.

A list of our upgraded additional critical illnesses and their definitions are listed in Appendix 2b.

Each **life covered** will be able to make one claim for each upgraded additional critical illness. After which, that **life covered** won't be able to make another claim for that condition. However, we will still cover them for the other upgraded additional critical illnesses.

It won't affect any of the other benefits chosen under the policy for each **life covered**.

What do we pay?

We'll pay the lower of:

- £25,000, or
- 100% of the **cover amount** shown in the **policy schedule**. For family income cover, we'll multiply this figure by the number of months left on your policy, and pay it as a lump sum.

If a claim meets our criteria for critical illness benefit and/or upgraded critical illness conditions, and at the same time meets our criteria for upgraded additional critical illness benefit, we'll only pay the **cover amount**.

Upgraded accelerated surgery benefit

On top of the surgical treatments covered under your **main benefits**, we'll also cover you for upgraded surgical treatments.

Our criteria

We'll pay this benefit if the **life covered** is placed on an NHS waiting list for one of the upgraded surgical treatments (set out below) and survives for at least 10 days.

Once we've accepted a claim the policy will end, unless you have chosen extra care cover and the **life covered** claiming under this upgraded accelerated surgery benefit is eligible to claim under extra care cover benefit. See page 8 for further details of how extra care cover works.

Upgraded surgical treatments:

- peripheral vascular disease
- pneumonectomy
- syringomyelia or syringobulbia
- ulcerative colitis.

See our full definitions of each of these upgraded surgical treatments in Appendix 2A.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**.

Hospital benefit

Our criteria

We'll pay this if the **life covered** is in hospital for more than seven consecutive nights. We pay it from the eighth night's stay (not the first seven nights).

This benefit will apply for each **life covered** under the policy.

What do we pay?

We'll pay £100 a night for a maximum of 30 nights.

The nights spent in hospital could be over one period, or a number of periods over the **policy term**.

If the **life covered** is admitted to hospital multiple times for the same or a related reason, they won't have to stay another seven nights before you can claim again.

If a claim meets the definition for **critical illness**, and/or an **upgraded critical illness condition** and at the same time, meets our definition of hospital benefit, we will only pay the **cover amount**.

Upgraded children's benefit

You can choose to upgrade your cover to include **upgraded children's benefit**. It will replace **children's benefit**.

Upgraded children's benefit

This includes upgraded children's critical illness benefit, child extra care cover, advanced illness, upgraded children's hospital benefit and upgraded children's death benefit, as described below.

It covers any **child** under the policy from birth up to their 22nd birthday at the time of their:

- diagnosis with one of our upgraded children's critical illnesses, child extra care cover conditions, or an advanced illness, or
- stay in hospital, or
- death.

We won't pay upgraded children's critical illness benefit, child extra care cover or advanced illness if the illness or condition was due to intentional injury caused by you.

Also, we won't pay if, before the policy **start date** or before the legal adoption of the **child:**

- the symptoms had already started, and/or
- either of the parents received counselling or medical advice in relation to the condition or were aware of the increased risk of the condition.

Upgraded children's critical illness benefit

We'll replace your children's critical illness benefit with upgraded children's critical illness benefit.

Our criteria

We'll pay this if a **child** meets the definition for one of our upgraded children's critical illnesses during the **policy term** and survives for at least 10 days.

See the full list of upgraded children's critical illnesses together with our definitions for them in Appendix 3A.

We'll accept one claim for each **child**, but the cover will continue for any other **child**.

What do we pay?

We'll pay £25,000.

Child extra care cover

Our criteria

We'll pay this if a **child** meets the definition for one of our child extra care cover conditions during the **policy term** and survives for at least 10 days. The exception to this is loss of independence claims (defined in Appendix 3B), where the **child** must survive at least 90 days.

Our full list of child extra care cover conditions and their definitions are in Appendix 3B.

We'll only accept one claim for each **child**, but the cover will continue for any other **child**.

Once we've accepted a claim for child extra care cover, that **child** won't be covered for any other benefit under the policy except for upgraded children's hospital benefit and upgraded children's death benefit.

What do we pay?

We'll pay:

- £50,000, or
- £25,000 if you've already made a claim for upgraded children's critical illness benefit.

Advanced illness

Our criteria

We'll pay this if a **child** meets our definition of advanced illness (set out below), during the **policy term** and survives for at least 10 days.

Advanced illness:

Confirmation by the **attending consultant** of a definite diagnosis of an advanced or rapidly progressing and incurable condition. With a life expectancy of no greater than 12 months.

We'll accept one claim for each **child**, but the cover will continue for any other **child**.

Once we've accepted a claim for advanced illness, that **child** won't be covered for any other benefit under the policy except for upgraded children's hospital benefit and upgraded children's death benefit.

What do we pay?

We'll pay £10,000.

Upgraded children's hospital benefit

Our criteria

We'll pay this if the **child** is in hospital for more than seven consecutive nights. We pay it from the eighth night's stay (not the first seven nights).

We won't pay if the stay in hospital is due to the **child** being born prematurely (before the 37th week of pregnancy).

This benefit applies for each **child** under the policy.

What do we pay?

We'll pay £100 a night for a maximum of 30 nights for each **child**.

The nights spent in hospital could be over one period or a number of periods over the **policy term**.

If the **child** is admitted to hospital multiple times for the same or a related reason, they won't have to stay another seven nights before you can claim again.

Upgraded children's death benefit

Our criteria

We'll pay this if a **child** dies during the **policy term**.

It includes stillbirth, where the **child** dies on or after the 24th week of pregnancy.

We'll pay it on top of any benefit we've already paid under **upgraded children's benefit**.

After a claim, the cover will continue for any other **child**.

What do we pay?

We'll pay £5,000.

Extra care cover

This benefit will pay out in one of three different circumstances as set out below.

Extra care cover #1

Our criteria

We'll accept a claim if, during the **policy term**, the **life covered** is totally and permanently unable to routinely perform at least three of the activities of daily living without the continual assistance of someone else, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

The activities of daily living we assess against are listed below.

Activities of daily living:

1. **Washing** – being able to wash and bathe unaided, including getting into and out of the bath or shower.
2. **Dressing** – being able to put on, take off, secure and unfasten all necessary items of clothing.
3. **Feeding** – being able to eat pre-prepared foods unaided.
4. **Continence** – being able to control bowel or bladder functions, whether with or without the use of protective undergarments and surgical appliances.
5. **Moving** – being able to move from one room to another on level surfaces
6. **Transferring** – being able to get on and off the toilet, in and out of bed and move from a bed to an upright chair or wheelchair and back again.

Once we've accepted a claim, the policy will end.

We won't pay this if during the **policy term** you've made, or are eligible to make, a claim for:

- a **main benefit**,
- an upgraded critical illness condition,
- the upgraded accelerated surgery benefit, or
- the total permanent disability benefit.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule** and at the same time we'll pay £50,000.

If you have chosen family income cover, we'll pay the £50,000 as a lump sum.

Extra care cover #2

Our criteria

We'll accept a claim if, during the **policy term**, the **life covered** is under age 55 when they either:

- meet our critical illness criteria for dementia, kidney failure, liver failure, Parkinson's disease, motor neurone disease or respiratory failure, or
- meet our criteria for Parkinson's plus syndrome or heart failure (if you've chosen **upgraded critical illness benefit**).

Once we've accepted a claim, the policy will end.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule** and at the same time we'll pay £50,000.

If you've chosen family income cover, we'll pay £50,000 as a lump sum.

Extra care cover #3

Our criteria

We'll accept a claim, if before the first anniversary of meeting our criteria for critical illness, upgraded critical illness conditions, total permanent disability, accelerated surgery or upgraded accelerated surgery (if chosen), (the "trigger claim"), the **life covered** is suffering from:

Permanent loss of independence

The total and permanent loss of the ability to perform routinely at least three of the six activities of daily living detailed in the extra care cover #1 section above, without the continual assistance of someone else, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication.

The claim must be as a direct result of the previous claim.

Extra care cover #3 must be claimed within 18 months of meeting our criteria for the "trigger claim".

Once we've accepted a claim, the policy will end.

What do we pay?

We'll pay £50,000 in addition to the **cover amount** already paid.

If you've chosen family income cover, we'll pay £50,000 as a lump sum.

Total permanent disability

We may ask you more underwriting questions before accepting your application to include this benefit on your policy.

Total permanent disability

Our criteria

We'll pay this benefit if the **life covered** meets our definition of total permanent disability during the **policy term**. We'll pay the **cover amount** shown in the **policy schedule**.

We have two definitions of total permanent disability (set out below):

- Own occupation, and
- Activities of daily work.

Your **policy schedule** will confirm which one applies to your policy.

Once we've accepted a claim, the policy will end, unless you've chosen extra care cover and the **life covered** claiming under this total permanent disability benefit is eligible to claim under extra care cover benefit.

Own occupation definition – unable before age 71 to do your own occupation ever again.

- "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.
- We'll pay if the **life covered** loses physical or mental ability, through an illness or injury before age 71, to carry out the material and substantial duties of their own occupation ever again.
- "Material and substantial duties" are those normally required for, and/or forming a significant and integral part of performing the **life covered's** own occupation. They can't reasonably be left out or changed.
- Specialists must reasonably expect the disability will last for life with no prospect of improvement, irrespective of when the cover ends or the **life covered** expects to retire.

- The policy doesn't cover disabilities for which specialists can't give a clear prognosis.
- Your **policy schedule** will confirm the definition applying to your policy is own occupation. However, if the **life covered** was not working (for profit or pay) immediately before the onset of the total permanent disability, we'll use the activities of daily work definition instead. We've detailed this next.

Activities of daily work definition – unable before age 71 to do three specified work tasks ever again.

- We'll pay this if the **life covered** loses the physical ability, through an illness or injury before age 71, to do at least three of the six work tasks listed ever again.
- The specialists must reasonably expect the disability will last for life with no prospect of improvement, irrespective of when the cover ends or the **life covered** expects to retire.
- The **life covered** must need the help or supervision of another person. They must be unable to perform the task on their own, even if using special equipment routinely available to help and having taken any appropriate prescribed medication.
- The policy doesn't cover disabilities for which specialists can't give a clear prognosis.

The work tasks are:

1. **Walking** – the ability to walk more than 200 metres on a level surface.
2. **Climbing** – the ability to climb up a flight of 12 stairs and down again, using the handrail if needed.
3. **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.
4. **Bending** – the ability to bend or kneel to touch the floor and straighten up again.
5. **Getting in and out of a car** – the ability to get into a standard saloon car, and out again.
6. **Writing** – the manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

What do we pay?

We'll pay the **cover amount** shown in the **policy schedule**.

Fracture cover

You can only add fracture cover to your policy if you don't already have it on any other policy taken out with Aviva Life & Pensions UK Limited. We may ask you more underwriting questions before accepting your application to add this benefit to your policy.

Fracture cover

Our criteria

We'll cover you for the fractures listed below.

We'll only pay out if the fracture happens at least seven days after the **start date** and before the policy **end date**.

We only pay out a successful claim once in each policy year for a fracture which occurs that year. A policy year runs from the **start date** to the day before the **anniversary date** shown in your **policy schedule**, and each subsequent **anniversary date**.

If you suffer from more than one fracture, at the same time we'll only pay for one of them. You can choose which one you claim for.

All fractures must be diagnosed by an **attending consultant**.

We won't cover you for a fracture which is classed as fatigue, stress, hairline, avulsion, chip or microfracture.

We won't cover a fracture that happens when taking part in any of the following: mountain biking or BMX; boxing, cage fighting or martial arts; rugby or Gaelic football; horse riding; or motor cycle sport.

If you make a claim for this benefit, all medical certificates and results of medical examinations must be provided by an **attending consultant**.

You can cancel the fracture cover option at any time six months after the **start date**. However, you won't be able to reinstate it and we won't refund any premiums.

If we accept a claim under this benefit, it won't affect the other benefits under your policy.

What do we pay?

If you suffer from any one of the following fractures, we'll pay:

Fracture	Amount
Skull (open fracture)	£6,000
Skull (closed fracture)	£4,000
Cheekbone	£1,500
Jaw	£3,000
Collar bone	£1,500
Shoulder blade	£2,000
Sternum	£2,000
Arm	£3,500
Ribs	£1,500
Vertebra	£2,500
Pelvis	£2,500
Wrist (we define the wrist as including the carpal bones, the distal radius or distal ulna)	£2,000
Upper leg	£6,000
Lower leg	£4,000
Ankle (we define the ankle as including the medial, posterior or lateral malleous)	£2,500
Knee	£6,000
Hand (excluding fingers and thumbs)	£1,500
Foot (excluding toes)	£2,000

Global treatment

Global treatment has extra definitions, which we use in this section. These definitions are in **bold** and have specific meanings. We explain these in the definitions for global treatment section.

You can only add the global treatment option to your policy if you don't already have the option on any other policy with an Aviva group company.

This option is provided together with **Best Doctors**, who are responsible for the **second opinion** service, and **Further**, who are responsible for medical and non-medical concierge services for overseas treatment.

Global treatment

We'll pay the cost of treatment outside of the **territory** if, during the **policy term**, you or your **child** are diagnosed with any one of the **serious illnesses,** or require a **medical procedure** set out below. The treatment must be recommended by the **second opinion** service.

Best Doctors will confirm the diagnosis. **Further** will recommend appropriate doctors and treatment centres and manage all necessary medical and administrative arrangements for treatment overseas.

It includes **expenses** that are incurred in relation to the treatment from the date the **preliminary medical certificate** is issued. We cover the medical, **medication**, travel, accommodation and miscellaneous **expenses** set out in the **expenses** section below.

It covers any **child** from birth up to their 18th birthday (or 21st birthday if in full-time education) at the date of starting the **second opinion** process.

If you're no longer **resident** in the **territory**, we'll cancel this option and your policy will continue without global treatment. If a **child** is no longer **resident** in the **territory**, they will need to return to the **territory** for confirmation of the initial diagnosis for you to make a claim for them under this option.

It won't affect any of the other benefits chosen under the policy for each **life covered**.

What do we pay?

We'll pay a maximum of £1,000,000 (including all **expenses**) in any 12-month period from the date the **preliminary medical certificate** is issued. This limit applies for each **life covered** (and/or any **child**), up to an overall maximum of £2,000,000 over the **policy term**.

Once the maximum limit has been reached, this benefit under the policy will end.

Start and end of cover

Global treatment covers you and your **child** for three years from the **start date**. At the end of this three year period, we will renew the cover, unless before that next **renewal date**:

(a) the **policy term** ends, in which case it will end on the **end date** of the policy; or

(b) you turn 85, in which case it will end on your 85th birthday; or

(c) you have reached the maximum benefit of £2,000,000 available under this option; or

(d) you can't renew your policy because:

- you are **resident** outside of the **territory**; or
- our relationship with **Best Doctors** and/or **Further**, comes to an end; or
- there has been any change of law, regulatory requirement or taxation which means we can no longer offer global treatment.

Renewal of cover

We'll contact you at least 30 days before the **renewal date** and tell you one of the following:

(a) The key features of global treatment won't change. If this happens, we'll automatically renew the option from the next **renewal date**. We'll automatically renew global treatment even if we change the amount you pay for it.

(b) The key features of global treatment will change. If this happens, we'll offer you the opportunity to renew from the **renewal date**. We'll ask you to confirm we can automatically renew the option at further **renewal dates**.

(c) We won't renew the option. If this happens, the policy will continue without global treatment and we'll remove the charge for it from your premium.

If you don't want to renew global treatment, you must tell us before the **renewal date**, so we don't renew the option and charge you for it. You can cancel the option at any time six months after the **start date**. However, you won't be able to reinstate it later and we won't refund your premiums.

Any new premium and changes will come into effect from renewal.

Indemnity period

You could still make a claim after the policy has ended in the following circumstances:

(a) If the policy ends as a result of a successful claim, you can claim under the global treatment option after the policy has ended (for a maximum of 36 months from the date the policy ended). To do this, the **serious illness** or **medical procedure** you're claiming for under this global treatment option must be directly related to the earlier claim under your policy.

(b) If you or your **child** have a **serious illness** or require a **medical procedure** for which a **second opinion** has been requested, but the policy subsequently ends as a result of a successful claim, the claim under global treatment can continue for a maximum of 36 months from the date the policy has ended.

If one of the above indemnity periods applies, all other benefits under the policy will have stopped when the policy ended, so you won't have to pay any premiums.

Provided treatment starts within 36 months of the policy ending, we'll cover the cost of any treatment you receive outside of the **territory** and the travel and accommodation **expenses** associated with that, until you or your **child** return to the UK. We'll cover the cost of any medication **expenses** that are incurred in the **territory** after the return of your **child** to the **territory**, provided they are incurred during the indemnity period.

Serious illnesses and medical procedures

Bone marrow transplant

Bone marrow transplantation (BMT) or peripheral blood stem cell transplantation (PBSCT) of bone marrow cells to you or your **child** originating from:

- you or your **child** (autologous bone marrow transplant), or
- a living compatible donor.

Cancer treatment

The treatment of:

- any malignant tumour including leukaemia, sarcoma and lymphoma, characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissues;
- any in situ cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues;
- all cancers which are histologically classified as any of the following:
  - pre-malignant
  - having borderline malignancy;
  - having low malignant potential.

Coronary artery bypass surgery

The undergoing of **surgery** on the advice of a **consultant** cardiologist to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

Heart valve replacement or repair

The undergoing of **surgery** on the advice of a **consultant** cardiologist to replace or repair one or more heart valves.

Live-donor organ transplant

A surgical transplant in which you or your **child** receive a kidney, a segment of liver, a pulmonary lobe or a section of pancreas from another living compatible donor.

Neurosurgery

Any surgical intervention, including minimally or non-invasive techniques of:

- the brain (or any intracranial structures), or
- benign tumours located in the spinal cord.

What don't we pay for?

We won't pay for:

- any diagnosis leading to a **medical procedure** that has not been confirmed by the **second opinion** service
- any initial diagnosis that came from a hospital or **consultant** outside of the **territory**
- any treatment that is not **medically necessary**
- any **experimental treatment**
- any **medical procedures** needed as a result of AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or any condition arising from them (including Kaposi's sarcoma), or any treatment for AIDS or HIV, with the exception of HIV infection (occurring after the policy **start date**) resulting from a blood transfusion, physical assault or an incident occurring during the course of performing duties of employment
- any medical procedures in connection with or derived from **cosmetic surgery**.

The following limits apply to these specific serious illnesses and **medical procedures**:

Coronary artery bypass surgery

- We won't provide cover for any correction of narrowing or blockage of coronary arteries treated using techniques other than bypass surgery, e.g. angioplasty surgery.

Live-donor organ transplant

We won't cover any of the following:

- organs listed under the live-donor organ transplant definition that involves stem cell treatment
- any organ transplant when the transplant is conducted as a self-transplant
- any transplant when you or your **child** is a donor for a third party, unless the recipient is also insured under global treatment
- if the transplant is made possible by the purchase of donor organs
- any disease caused by an organ transplant, unless it is a **serious illness** or requires a **medical procedure**. We will cover complications directly associated with transplant **surgery** covered by the global treatment **option** occurring during **surgery** or post-**surgery** recovery outside of the **territory** as we'll consider it a continuation of the transplant procedure.

Treatment for your child

To make a successful claim for your **child:**

- the symptoms must not have started; and/or
- the illness or condition must not have been diagnosed; and/or
- neither parent must have received counselling or medical advice in relation to the condition or have been aware of the increased risk of the condition before the policy **start date** or before the legal adoption of the **child.**

Medical expenses

What we cover

Hospital charges

Relating to:

- accommodation, meals and general nursing services provided during your, or your **child's** stay in a room, ward or section of the hospital or in an intensive care or monitoring unit
- other hospital services including those provided by a hospital outpatient department, as well as **expenses** relating to the cost of an extra or **travelling companion's** bed if the hospital provides this service;
- the use of an operating room and all related services.

Day clinic

- Day clinic or independent welfare centre **expenses**, but only if the treatment, **surgery** or prescription would have been covered by us if provided in hospital.

Consultant treatment

- **Consultant expenses** relating to examination, treatment, medical care or **surgery**.

Stay in hospital

- **Expenses** relating to **consultant** visits during your, or your **child's** stay in hospital.

Medication

- For **medication** from a medical prescription while you or your **child** are hospitalised for treatment of a covered illness or **medical procedure**. We cover **medication** prescribed for post-operative treatment for 30 days from the date you or your **child** have completed the treatment received outside of the **territory**.

  However, we only cover these when you buy them before returning to the **territory**. Please see below for separate benefits for **medication expenses** incurred in the **territory**.

Hospital transfers

- For transfers and transportation by ground or air ambulance for you or your **child** where their use is indicated and prescribed by a **consultant** and pre-approved by **Further**.

Medical treatments

Expenses relating to the following medical and surgical services including **reconstructive surgery**, treatments or prescriptions:

- administration of plasma and serum;
- angiograms;
- blood transfusions;
- chemotherapy;
- computerised tomography (CT scan);
- echocardiography (ECHO);
- electrocardiograms (ECG);
- electroencephalograms (EEG);
- **expenses** relating to the use of oxygen, application of intravenous solutions and injections;
- for anaesthesia and administration of anaesthetics, provided they are performed by a qualified anaesthetist;
- laboratory analysis and pathology;
- myelograms;
- radioactive isotopes;
- radiotherapy;
- x-rays for diagnostic purposes;
- other similar tests and treatments required for the diagnosis and treatment of a covered illness or **medical procedure**, when performed by a **consultant** or under medical supervision.

Living donor

For services provided to a living donor during removal of an organ or tissue to be transplanted to you or your **child**. This includes:

- the investigation procedure for locating potential donors
- hospital services provided to the donor, including accommodation in a hospital room, ward or section, meals, general nursing services, regular services provided by hospital staff, laboratory tests and use of equipment and other facilities (excluding items for personal use which are not required during the process of removal of the organ or tissue to be transplanted)
- **surgery** and medical services for the removal of a donor's organ or tissue to be transplanted to you or your **child.**

Bone marrow transplant

For services and materials supplied for bone marrow cultures in connection with a tissue transplant to be applied to you or your **child.**

What we don't pay for

Any medical **expenses** (with the exception of **medication expenses** set out below) that are incurred in the **territory.**

Any treatment that is not arranged under the **preliminary medical certificate**.

Expenses incurred in buying or hiring any of the following equipment or similar items:

- orthopaedic appliances; corsets; bandages; crutches; artificial members or organs; wigs (even where their use is considered necessary during chemotherapy treatment); orthopaedic footwear; trusses; or other similar equipment or items.
- wheelchairs; special beds; air conditioning appliances; air cleaners; or any other similar equipment or items.

Any type of **prosthesis** that are:

- not fully inserted into the body, and
- not required as a direct result of the damage to a structure made by the **medical procedure(s)** arranged under this global treatment option.

Medical expenses continued

Alternative medicine:

Any charges made for the use of **alternative medicine**, even where specifically prescribed by a **consultant**.

Any expense incurred in a different hospital from the authorised hospital stated in the **preliminary medical certificate**.

Any expense incurred for confinement services, home health care or services provided in a convalescence centre or institution, hospice or nursing home. This is the case, even where such services are required or necessary as a result of a **serious illness** or **medical procedure**.

Cerebral syndrome or impairment:

Any charges for medical attention or confinement in cases of:

- cerebral syndrome (presence of a cerebral disorder or damage to the brain resulting in the partial or total impairment of the brain functions), or
- senility, or
- cerebral impairment regardless of the status of their development.

Any charges made for any treatment, service, supply or medical prescription for a disease for which the best treatment is a transplant, is covered by global treatment.

Medication expenses

What we cover

If treatment of any of the **serious illnesses** or **medical procedures**, which are paid for under this option, resulted in a hospital stay for three nights or more, we'll pay the cost of **medication** purchased in the **territory**. The maximum limit for this is £50,000 over the **policy term**.

We'll only cover the **medication expenses** if:

- the **medication** is recommended as necessary for ongoing treatment through **Further** by the international **consultant** who treated you or your **child**
- the **medication** recommended by the international **consultant** has been licensed and approved by the corresponding medical authority or agency in the **territory** and its prescription and administration is regulated
- the **medication** is available for purchase in the **territory**
- the **medication** requires prescription by a **consultant** in the **territory** and
- no single prescription exceeds a dose for consumption longer than two months.

What we don't pay for

The cost of **medication** funded by the NHS or covered by any other insurance policy you hold.

Any costs associated with administering the **medication**.

Any **medication expenses** you build up which you don't send to us within 180 days of purchase.

Any **medication** that is not **medically necessary.**

Travel, accommodation and miscellaneous expenses

What we cover

Travel and accommodation

We'll pay for **expenses** for economy class travel to and from the agreed hospital indicated in the **preliminary medical certificate**. We'll also arrange and pay for any necessary accommodation for:

- you and a **travelling companion**, or
- you, your **child**, and another **travelling companion** (if your **child** is receiving the treatment under the global treatment option), and/or
- a living donor (if applicable).

We'll also pay you a daily allowance of £100 for every day you or your **child** spend in hospital outside of the **territory**, for treatment arranged under the **preliminary medical certificate**, up to a maximum of 60 consecutive days for each claim made under the global treatment option under the policy.

Repatriation expenses

If you, your **child** or a living donor dies whilst receiving treatment approved by the **preliminary medical certificate**, we'll pay the costs relating to transporting the body. We'll also pay the minimum costs necessary for administrative formalities, embalmment and the coffin in which the body is transported back to the **territory**.

What we don't pay for

Any travel arrangements not associated with travel from and to a permanent address in the **territory**.

Any **expenses** for accommodation or transportation arranged by you, a **travelling companion** or a living donor.

Any interpreter's fees, telephone and other charges for items for personal use not of a medical nature or for any other service provided to relatives or **travelling companions**.

Any breakfast, meals and incidental costs incurred at the hotel. If you pay for an upgrade to your hotel accommodation, you will bear the full cost of the upgrade.

You, your **child** or **travelling companion** to obtain a passport to enable travel outside of the **territory**.

Making a claim under the global treatment option

You can make a claim at any time during the **policy term** or within the indemnity period described above. You can make a claim even if you've made other claims under your policy.

Initially, **Best Doctors** will deal with your claim. You can contact them on 0800 085 6605.

Best Doctors will then refer you to **Further**, who will assess whether you or your **child's** initial diagnosis is covered under the global treatment option. This initial diagnosis must come from a **consultant** in the **territory**.

If it's covered, **Further** will arrange for a **second opinion** to be carried out by **Best Doctors**, to confirm the diagnosis and the cover provided under this option.

Following this confirmation, you'll be given a copy of the **second opinion** report. If the report confirms that the diagnosis concerns a **serious illness** or a **medical procedure**, you must tell **Further** if you or your **child** want to receive treatment outside of the **territory**. **Further** will then begin to arrange treatment under the global treatment option.

Increasing cover

This benefit allows you to automatically increase your **cover amount** each year without any more health and lifestyle questions being asked.

Increasing cover

This will also increase the benefits payable for:

- additional critical illness
- **children's benefit** (except children's hospital benefit).

And, if selected, it will also increase the benefits payable for:

- **upgraded critical illness benefit** (except hospital benefit)
- **upgraded children's benefit** (except upgraded children's hospital benefit)
- total permanent disability, and
- extra care cover.

Wherever we refer to **cover amount** in this section, it also includes the amount you may be entitled to under any of the above optional benefits.

We won't increase your **cover amount** if it would mean the total amount of cover a **life covered** has with us (on this policy and any others) exceeds the maximum we allow at the time. We'll tell you if this happens.

The way increasing cover applies depends on whether you have level or family income cover.

Level cover

With level cover, you can choose how your **cover amount** will increase from three increasing cover options:

a) Increase your **cover amount** based on the Retail Prices Index

Your **cover amount** will increase based on the percentage increase in the **Retail Prices Index (RPI)** over the 12-month period ending 12 weeks before the start of the month of your policy's **anniversary date**.

If you choose this option:

- The maximum increase in your **cover amount** will be 10% each year.
- Your premium won't increase by more than 15%, unless you have also chosen reviewable premiums where a combined increase in premium could exceed 15%.
- If the change in RPI is 0% or below, your **cover amount** – and your premium – will stay the same.

Or

b) Increase your **cover amount** by 3% on each **anniversary date** of your policy.

Or

c) Increase your **cover amount** by 5% on each **anniversary date** of your policy.

If your **cover amount** increases, your premiums will also increase each year. We'll calculate the increase in premium by multiplying the percentage increase in the **cover amount** by 1.5. We'll then multiply that amount by the current premium to work out what the increase in your premium will be.

When will I be told about any increase?

We'll write to you at least eight weeks before the **anniversary date** to tell you how much your **cover amount** and premiums will increase by.

The increase will take effect from the **anniversary date**.

You can choose not to increase your **cover amount** if you don't want to pay the higher premium. If you do this, your **cover amount** and your premiums will stay the same. You must tell us as soon as possible before the **anniversary date** if you want us to cancel the increase. We'll reinstate the increasing cover option the following year.

If you decide against the increase three times in a row, we'll remove increasing cover from your policy. You can't add it again in the future.

Family income cover

With family income cover, you can choose from two options how your **cover amount** will increase:

a) Increase your **cover amount** by 3% on each **anniversary date** of your policy.

Or

b) Increase your **cover amount** by 5% on each **anniversary date** of your policy.

Your **cover amount** will continue to increase until the end of the policy, even if we've accepted a claim.

Your premiums won't increase.

Renewal option

This option is only available if we accept your policy on **standard terms**.

It's not available if you have reviewable premiums or if you've taken out the increasing cover option.

Renewal option

This benefit allows you to renew your cover on your policy **end date** without us asking you any more health and lifestyle questions.

You can use this option if you haven't already made or you're not eligible to make a claim for the **main benefit**.

You can't use the renewal option if you have made or you're eligible to make a claim for an upgraded critical illness condition, upgraded accelerated surgery benefit, total permanent disability or extra care cover.

The new policy

The new policy must:

(a) start immediately after your original policy ends

(b) have a **policy term** no longer than your original policy

(c) have a cover amount less than or equal to the **cover amount** on your original policy.

The new policy can include any of the benefits and options that were on your original policy as long as they are available at the time and you meet any eligibility criteria. You can only have the waiver of premium option if the **deferred period** on your new policy is not shorter than on your original policy.

If you've already claimed for an additional critical illness, upgraded additional critical illness, **children's benefit** or **upgraded children's benefit** under your original policy, you won't be able to claim for that same condition on your new policy.

Your new policy will be based on the policy conditions in force at the time of the request. We'll be base the premium you pay on the personal circumstances of the **life covered** and the rates available at the time.

If your original policy:

- is a **single policy** – the new policy has to be a **single policy**
- is a **joint policy** – the new policy can be either single or joint. Both policyholders need to agree to the new policy.

You can't change the **lives covered** on the new policy.

Waiver of premium

We may ask you more underwriting questions before accepting your application to add this benefit to your policy. This option is only available until the **life covered**, or the eldest **life covered** for a **joint policy**, turns 71.

Waiver of premium option

We'll pay your premiums if the **life covered**:

- is unable to perform the duties of their own occupation (as set out below) because of their illness or injury, or
- meets the below activities of daily work criteria.

We'll consider the **life covered's** ability to perform their own occupation, unless they stopped performing any occupation (for profit or pay) more than 12 months before the start of the illness or injury. In these circumstances, we'll apply the activities of daily work definition.

Own occupation

We'll pay your premiums if the **life covered** is unable to perform the material and substantial duties of their own occupation.

"Material and substantial duties" are those normally required for, and/or forming a significant and integral part of performing the **life covered's** own occupation. These duties can't reasonably be left out or changed.

Activities of daily work:

We'll pay this if the **life covered** is unable to perform at least two of the work tasks listed below.

The **life covered** must need the help or supervision of another person. They must be unable to perform the task on their own, even if using special equipment routinely available to help and having taken any appropriate prescribed medication.

Activities of daily work: continued

The work tasks are:

1. Walking – the ability to walk more than 200 metres on a level surface.
2. Climbing – the ability to climb up a flight of 12 stairs and down again, using the handrail if needed.
3. 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.
4. Bending – the ability to bend or kneel to touch the floor and straighten up again.
5. Getting in and out of a car – the ability to get into a standard saloon car, and out again.
6. Writing – the manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

What happens when we accept a claim for waiver of premium?

After we've accepted a claim, there is a **deferred period** before we start paying your premiums. So you will need to carry on paying your premiums until the end of the **deferred period**.

When the **deferred period** ends, we'll pay your premiums until the earliest of:

- the policy **end date**
- the date the **life covered** is able to perform the duties of their own occupation or they no longer meet the activities of daily work criteria as described above
- the date the **life covered** starts any type of work (for profit or pay)
- the date we accept a claim for the **main benefit**, **upgraded critical illness benefit**, total permanent disability benefit and extra care cover benefit (if selected)
- the **life covered** turns 71. For joint policies this will be when the eldest **life covered** turns 71.

If we stop paying your premiums and your policy has not ended, you will need to restart paying them to keep your policy in force.

For us to continue paying your premiums, we'll need evidence that the **life covered** is still unable to perform their own **occupation** or meet the activities of daily work criteria.

You can't claim waiver of premium if we establish that the **life covered** is living outside of the following countries for more than 13 consecutive weeks in any 12-month period:

- Andorra, Australia, Canada, the Channel Islands, the European Union, the Faroe Islands, Gibraltar, the Isle of Man, Liechtenstein, Monaco, New Zealand, Norway, San Marino, Switzerland, the UK, USA or the Vatican City.

Additional benefits – Critical illness cover

Life change benefit

This benefit will only be included from the start of your policy if:

- we accepted your policy on **standard terms**
- the eldest **life covered** is under age 55 at the policy **start date**
- you are the policyholder as well as the **life covered**
- you didn't take out your policy under the life change benefit or separation benefit.

Life change benefit

This benefit lets you take out more cover through an additional policy without answering any more health and lifestyle questions if the **life covered's** circumstances change in one of the ways described below.

You can use this benefit six months from the **start date**.

You must take out the new policy within 90 days of the life change happening and you must send us the evidence we need.

Life change	Evidence needed
Marriage or civil partnership	Marriage or civil partnership certificate
Divorce or dissolution of civil partnership	Decree absolute or dissolution order
Separation	Evidence of new mortgage, mortgage transfer or new separate addresses
Becoming a parent	Birth or adoption certificate
Increased mortgage due to a house move or purchase, or carrying out home improvements	Evidence of new mortgage or increase on existing mortgage, or builder's receipts for work carried out
At least 20% increase in salary due to change of employer or promotion	Copy of recent payslips dated within 90 days of each other

You can use the life change benefit as many times as you like as long as you take out the new policy before the eldest **life covered** turns 55.

If the policyholder transfers ownership of the policy to someone else, you can still use life change benefit provided the **life covered's** circumstances change in one of the ways described above.

You can't use it if you've made a claim for any benefit except for hospital benefit, **children's benefit** or **upgraded children's benefit**.

You can't use it if you are eligible to make a claim for any benefit.

The premium for the new policy must meet the minimum premium limit that applies at the time.

If your original policy is a **single policy**, the new policy has to be a **single policy**.

If your original policy is a **joint policy**, your new policy can be either **single** or **joint**. Both policyholders need to agree to the new policy.

You can't change the **lives covered.**

The new policy

The new policy can include the options and benefits that are on your original policy as long as they're available at the time (and any eligibility criteria are met) except for:

- the life change benefit
- the renewal option
- increasing cover
- fracture cover
- global treatment.

You can only have the waiver of premium option on the new policy if the **deferred period** is no shorter than the one on your original policy.

If the original policy was on a family income basis, the new policy must also be on a family income basis. Otherwise, you can set up the new policy on a level, decreasing or family income basis.

We'll base the premium you'll pay for any new policy on the rates available at the time of the request and the **personal circumstances** of the **life covered**. The policy conditions in force at the time will apply to the new policy. You also need to meet the eligibility criteria in force at the time you apply for the new policy.

There are certain limits on life change benefit, depending on whether you have level, decreasing or family income cover:

For level cover or decreasing cover:

For mortgage increases, the new cover amount can't be more than the mortgage increase.

The total cover amount for all the policies you take out using the life change benefit must not be more than the lower of:

- £200,000, or
- the original **cover amount**.

The new policy must end before the eldest **life covered** on your original policy turns 70.

For family income cover:

The total cover amount for all the policies you take out using the life change benefit must not be more than the lower of:

- the original **cover amount**, or
- the equivalent of £8,000 a year.

The new policy must end on the earlier of:

- the **end date** of the original policy, or
- the day before the oldest **life covered** turns 70.

Separation benefit

This benefit only applies if you have a **joint policy**.
It will be included in your policy if:

- we accepted your policy on **standard terms**, and
- the eldest **life covered** is under age 55 at the policy **start date**, and
- you are the policyholder as well as the **life covered**.

Separation benefit

This benefit lets you split your **joint policy** and take out a new **single policy** if you separate, without having to answer any more health and lifestyle questions. Either one or both of the policyholders can take out a new **single policy**.

You can use this benefit six months from the **start date**.

You must take out the new policy within 90 days of the separation. You must also send us the evidence we need:

Separation	Evidence needed
Divorce or dissolution of civil partnership	Decree absolute or dissolution order
Separation	Evidence of new mortgage, mortgage transfer or new separate addresses
Mortgage transferred into one name only	Evidence of mortgage transfer
Moving into a different house	Evidence of new mortgage or new address

In addition, you can use the separation benefit as long as:

- you and the other **life covered** agree to cancel the original policy, and
- you take out the new policy before the eldest **life covered** turns 55.

You can't use it if you have made a claim for any benefit except for hospital benefit, **children's benefit** or **upgraded children's benefit**.

You can't use it if you are eligible to make a claim for any benefit.

The premium for the new policy must meet the minimum premium limit that applies at the time.

The new policy can only start when your original policy has been cancelled. It has to end before you turn 70 and have a cover amount which is less than, or equal to, the current **cover amount**. If you have family income cover, the new policy can't last longer than your original policy.

You can only use the separation benefit once.

The new policy can include the options and benefits on your original policy as long as they're available at the time (and you meet any eligibility criteria) except for:

- the life change benefit
- the renewal option
- separation benefit.

You can only have the waiver of premium option if the **deferred period** on your new policy is no shorter than the one on your original policy.

If the original policy was on a family income basis, the new policy must also be on a family income basis. Otherwise, you can set up the new policy on a level, decreasing or family income basis.

We'll base the premium you'll pay for any new policy on the rates available at the time of the request and the **personal circumstances** of the **life covered**. The policy conditions in force at the time will apply to the new policy.

Making changes to your policy

You can make certain changes to your policy from six months after the **start date**, unless you're claiming or eligible to make a claim. If you make any changes, they will apply from the date your next premium is due.

We've set out the changes you can make in the table below. Depending on the type of change, we may either amend your existing policy or issue you with a new policy.

Type of change	Amend existing policy	Issue a new policy
Reduce **cover amount**	✓	✗
Increase **policy term**	✓	✗
Change premium frequency	✓	✗
Remove selected option	✓	✗
Increase **cover amount**	✗	✓
Reduce the **policy term**	✓	✗

Changes needing an amendment to your policy

The following applies to the above changes which require an amendment to your existing policy:

- We won't ask you any more health and lifestyle questions, unless you want to increase the **policy term**.
- If you want to increase the **policy term**, we may need to ask some more health and lifestyle questions. Depending on the answers, we may not be able to change your policy. You can't increase the **policy term** if your policy includes increasing cover or renewal option. We'll use the premium rates available when we make the change, based on the **personal circumstances** of the **life covered**.
- For all other changes, we'll use the original premium rates based on the **personal circumstances** of the **life covered**.
- If you want to remove an option, we'll remove the charge for that option from your premium.
- After you've made any of the above changes, your premium can't be lower than the minimum premium limit which applies at the time we agree to your request.

- If you have family income cover and you chose the increasing cover option, you can't later remove it from the policy.
- These **policy conditions** will continue to apply to your amended policy.

Increasing your cover amount

If you increase the **cover amount**, your original policy will remain in force and we will issue a new policy for the further amount.

We may need to ask some more health and lifestyle questions. Depending on the answers, we may not be able to carry out the change. If we can carry out the change, the policy conditions in force at the time will apply to the new policy.

Making a claim

If you need to make claim, please contact us on **0800 158 3467**
from outside of the UK, please call **+44 1603 603 479**.
Our claims line is open Monday to Friday 8.00am-6.00pm, Saturday 8.00am-2.00pm.
Calls may be monitored and will be recorded.
For claims under the global treatment option, please read that section of these **policy conditions**.

Before we can pay a claim we need to assess it

To do this, we'll ask for some important information. If we ask for information from third parties, we'll pay for it. If you want to, you can provide additional evidence at your own expense.

The kind of information we need may include, but isn't limited to:

- Proof that the event giving rise to the claim has happened
- Proof that a **child** has died or met our definition for **children's benefit** or **upgraded children's benefit**
- Proof of who legally owns the policy
- Written consent that lets us:
  - access the medical records or reports of the **life covered** or **child**
  - receive the results of any medical examinations or tests of the **life covered**
  - Conversations with, and reports from, third parties such as coroners, **attending consultants**, employers and the police.

If you make a claim, all medical certificates and results of medical examinations must be provided by medical practitioners. These practitioners must be resident and practising in one of these places:

- Andorra,
- Australia,
- Canada,
- the Channel Islands,
- the European Union,
- the Faroe Islands,
- Gibraltar,
- the Isle of Man,
- Liechtenstein,
- Monaco,
- New Zealand,
- Norway,
- San Marino,
- Switzerland,
- the UK,
- USA or
- the Vatican City.

For extra care cover, total permanent disability and waiver of premium claims, we may ask the **life covered** to have regular medical examinations. If we do, we'll appoint a medical examiner to carry them out.

For waiver of premium claims, the **life covered** must take all necessary steps to help their recovery.

If you have family income cover and we accept a claim, you can decide to take the **cover amount** as a cash lump sum instead of monthly instalments at any time. However, if you do, we'll have to recalculate your benefit. This means it will be less than the total amount of the monthly instalments. We'll calculate the reduction fairly and reasonably, so it reflects how much it costs us to pay out in advance.

If we accept a claim for the **main benefit** under the policy, that doesn't automatically mean you will be eligible to claim under the global treatment option. We'll assess claims for global treatment in their own right, as described in the global treatment option section (if selected).

When we assess a claim, we rely on the information we're given. If any of the information is untrue or incomplete, it could affect whether we pay a claim or not, and may mean we won't pay a claim. It may also mean we reclaim the money, if we've already paid. If this happens, we won't make any further payments. We may also cancel the policy without refunding any premiums.

This doesn't affect any other legal rights we have.

If we accept a claim, we'll make any relevant payment to the person who is legally entitled to receive it.

We won't be able to pay anything if:

- you die having not met our conditions for a claim
- your policy has ended because you haven't paid your premiums
- you've cancelled your policy
- you're diagnosed with, or have surgery for, something that isn't defined in the policy
- you're not covered for the benefit you claim for, or
- you get ill outside of the policy term.

This isn't the kind of policy that you can 'cash in' – so you don't get any money if you cancel it.

Your premiums

You need to pay your premiums to keep your policy in force.

You can pay premiums yearly or monthly by direct debit.
All direct debits need to come from a bank or building society in the UK, the Channel Islands, the Isle of Man or Gibraltar, in the currency of the UK.

Your **policy schedule** will show the initial premium you'll pay, together with the date it and subsequent premiums are due. You have 60 days from each due date to pay your premium. If you have to make a claim during this period, we'll deduct the unpaid premium from any benefit we pay.

If you don't pay your premiums within the 60 day period, we'll cancel your policy. If this happens, you won't be able to make a claim.

Your premiums can be guaranteed or reviewable.
Your **policy schedule** will show which premiums you have.

Guaranteed premiums won't increase over the **policy term**, unless you:

- make changes to your policy, or
- have selected the increasing cover option, or
- have selected the global treatment option.

Your **policy schedule** will show which options you have.

Reviewable premiums

Your **policy schedule** will confirm whether you have reviewable premiums.

We review your premiums every five years over the **policy term** to determine if you're paying the right price for the **cover amount** you've chosen.

If our review shows your premium needs to change, we'll assess the change fairly. We'll use certain assumptions to work out what the new premium should be. We won't look at the **personal circumstances** of the **life covered**.

We'll base our assumptions on our view of the following factors:

- The expected impact of medical advances and trends which may affect our expectation of future claims
- Industry developments and our claims experience
- Changes to legislation, taxation and regulation
- The amount, timing and cost of claims we're paying now, and those we may pay in the future.

Your premium may increase or decrease based on our assumptions at the review date. There are no limits on how much your premium can change by.

Following our five-yearly review, we'll write to you to let you know the outcome of the review at least 30 days before the **anniversary date**. After that, one of the following will happen:

- If the change is less than 2% or 50p, your premium will stay the same
- If your premium goes down, we'll automatically change your direct debit
- If your premium goes up, you have two options:
  (a) you can pay the increased premium and we'll automatically change your direct debit.
  (b) you can keep your premium the same and reduce your **cover amount**. If you want to do this, you need to let us know before the **anniversary date**. If you don't tell us, we'll increase your premium. It's up to you to check that the **cover amount** is right for you.

Any changes to your premium, or your **cover amount**, will apply from the fifth anniversary of your policy and every five years after that.

General

Changing your details

You need to let us know if your contact details, or those of any **life covered**, change.

Acceptance of instructions

We can't accept any instruction, request or notice from you until we receive all the information we need. We'll tell you what kind of information or documentation we need.

Cancelling your policy

You have a 30 day cooling off period to change your mind. If you cancel within this period, we'll refund any premiums you've paid. The cooling off period begins on the later of:

- the day we tell you when your policy will start, and
- the day you receive your policy documents.

You can still cancel the policy after the cooling off period ends, or remove any of the options (six months from the **start date**), but we won't refund your premiums. If you cancel your policy, you won't be able to make a claim.

Eligibility

You must be at least 18 to apply for this policy and, if different, the **life covered** must also be 18.

At the time you apply for this policy you must:

1. be currently physically living in the UK, the Channel Islands, the Isle of Man or Gibraltar, and
2. regard the UK, the Channel Islands, the Isle of Man or Gibraltar as the location of your main residence, and have no current intention of moving outside of any of those territories permanently, and
3. either
    a. be a citizen of that territory or a British Overseas Territories citizen, or
    b. have been granted permission to settle permanently in the named territory, or
    c. be applying for a mortgage on a residential property which is, or will be, your main residence in that territory.

You need to tell us if you move outside of the UK, the Channel Islands, Isle of Man or Gibraltar, and your main residence is in another territory. We may need to change, reduce or remove any of your policy terms. We'll give you details once you've told us. You should seek your own independent advice if you wish to continue with your policy after you move to another territory.

General conditions

Policy amendments

We may change these **policy conditions** for any of the following reasons:

- To respond, in a proportionate manner, to changes in:
    - the way we administer these type of policies
    - technology or general practice in the life and pensions industry
    - taxation, law or the interpretation of the law, decisions or recommendations of an ombudsman, regulator or similar body, or any code of practice with which we intend to comply.
- To correct errors if it is fair and reasonable to do so.

If we think any change to these **policy conditions** is to your advantage, we'll make it immediately and tell you afterwards. We'll also do this if we have to make the change due to regulatory requirements.

If any change is to your disadvantage, we'll aim to tell you in writing at least 60 days before we make it. However, external factors beyond our control may mean we have to give you less notice.

If you're not happy with any change we make to your policy, you can cancel it.

Incorrect information

If the date of birth of any **life covered** is wrong, we'll base the payment we make for any successful claim on the correct date of birth. We'll tell you if this happens.

If the correct date of birth of any **life covered** when you took out your policy would put them outside our limits, we'll cancel your policy. If this happens, we'll tell you.

We rely on the information provided to us. If any of it is untrue or incomplete and would have affected our decision to provide your policy, we may:

- change the terms of your policy
- change your premiums
- cancel your policy and refund the premiums you've paid (without interest).

If we cancel your policy, you won't be able to make a claim.

Third party rights

This policy does not give any rights to anyone except you and us.

With your agreement, we may change or cancel this policy without reference to or consent from any other person.

Fairness of terms

We'll always act reasonably and treat you and all of our customers fairly.

These **policy conditions** will apply to your policy so long as they are not held by a relevant court or viewed by the Financial Conduct Authority or by us to be unfair contract terms. If a term is unfair it will still apply, as far as possible, but without any part which makes it unfair.

General

If you want to transfer ('assign') the policy to someone else, you must tell us in writing before we can pay a claim. Where appropriate, words in the singular include the plural and vice versa.

Law

This policy is governed by the law of England. Your contract will be in English and we will always write and speak to you in English.

Definitions

Throughout these **policy conditions**, we've highlighted defined terms in **bold** type (except for personal terms like "we" and "you"), so you know when they apply.
We've set out the meanings of these words below.

"You" or "your" refers refers to the policyholder(s) named in the **policy schedule** or anyone else who becomes the legal owner of the policy.

"We," "us" or "our" means Aviva Life & Pensions UK Limited.

Anniversary date

The anniversary of the **start date** shown in the **policy schedule**.

Attending consultant

A surgeon, anaesthetist or physician who is legally entitled to practice medicine or surgery. They must have attended a recognised medical school and be recognised by the relevant authorities in the country in which any treatment takes place as having a specialised qualification in the particular field.

Child

The natural, step, legally adopted and/or future children of any **life covered**.

Children's benefit

This includes the benefits children's critical illness, children's hospital benefit and children's death benefit.

Cover amount

The amount we pay for the **main benefits** under this policy. It also includes the amount we pay for extra care cover #1 (if applicable). The cover amount is shown in your **policy schedule** together with your chosen basis for receiving the amount upon a successful claim (that is, level decreasing or family income cover). For family income cover, you'll see the cover amount as a monthly figure. Following a successful claim, we'll pay this monthly cover amount for each full month until the policy **end date**.

Deferred period

The number of consecutive months which must pass before the policyholder becomes entitled to receive the benefit provided by the waiver of premium option. The deferred period is shown in your **policy schedule**.

End date

The date that cover under this policy will end. This is shown in your **policy schedule** either as a specific date, or an expiry age. If you have family income cover and have made a successful claim, your monthly instalments will stop on the **end date**.

Joint policy

The policy can cover up to two people. A **joint policy** will only pay out once following a successful claim for the **main benefit**, total permanent disability benefit, upgraded critical illness, conditions, or upgraded accelerated surgery benefit. If you've added extra care cover, the **life covered** who successfully claimed may also be eligible to claim for this after the policy ends.

Life covered (or lives covered)

The person whose life is being covered. There can be more than one if you have a **joint policy**.

Main benefits

The **main benefits** are critical illness benefit and accelerated surgery benefit.

Personal circumstances

These can include the age, smoker status (both previous and current), health and lifestyle of the **life covered**.

Policy conditions

This document forms our contract of insurance with you. The application that you made (and which we have accepted) and the **policy schedule** also form part of the contract. You should read these documents together with these **policy conditions**.

Policy schedule

This shows the specific detail of your policy, such as:

- the life or lives covered
- the cover amount
- whether we'll pay the main benefits on a level, decreasing or family income basis
- how much your policy will cost, and
- any optional benefits or additional benefits you've chosen.

"Policy schedule" also includes any subsequent changes to your policy, which we'll confirm to you in writing at the time.

Policy term

This is the period your policy is in force, from the **start date** until the **end date**.

Retail Prices Index (RPI)

The monthly index calculated by the government that demonstrates the movement of retail prices in the UK, or an equivalent replacement of that index.

Single policy

A policy which covers the life of just one person.

Standard terms

The premium and benefits we quote before we complete the underwriting process.

If the premiums and benefits for your policy are the same after the underwriting process, you'll be on **standard terms**. If, following our underwriting process, we can only offer cover with a higher premium than first quoted, or with certain benefits excluded, or both, this would not be **standard terms**. We'll have told you whether you were accepted on **standard terms** when confirming our decision on your application.

Start date

The date on which cover under this policy starts. It's shown in the **policy schedule**.

Upgraded children's benefit

This includes the benefits upgraded children's critical illness, child extra care cover, advanced illness, upgraded children's hospital benefit and upgraded children's death benefit.

Upgraded critical illness benefit

This includes upgraded critical illness conditions, upgraded additional critical illness benefit, upgraded accelerated surgery benefit and hospital benefit.

Definitions for global treatment only

In addition to the main definitions in these **policy conditions**, the following definitions apply only to the global treatment option:

Alternative medicine

Includes medical and health care systems, practices and products that are not presently considered to be part of conventional medicine or the standard treatments including but not limited to acupuncture, aromatherapy, chiropractic medicine, homeopathic medicine, naturopathic medicine and osteopathic medicine.

Best Doctors

Best Doctors UK Limited, part of Best Doctors Inc. Best Doctors specialises in the provision of care services and specialised medical information. Best Doctors Services SL at C/Almagro 36, 1a planta, 28010, Madrid, Spain, registered in the Mercantile Registry in Madrid under haja m-554734, tomo 30823, folio 126 and tax number (CIF) B86661857.

Consultant

An **attending consultant** that has a specialised qualification in the field of, or expertise in the treatment of, the disease or illness.

Cosmetic surgery

Procedures enhancing, reducing, lifting or removing a part of the body performed to improve and correct a structural defect. This includes removal of scars, birthmarks or normal evidence of ageing.

Expenses

Means the medical, **medication**, travel, accommodation and miscellaneous **expenses** we cover under this global treatment option.

Experimental treatment

A treatment, procedure, course of treatment, equipment, medicine or pharmaceutical product, intended for medical or surgical use, which has not been universally accepted as safe, effective and appropriate for the treatment of illnesses or injuries by the various scientific organisations recognised by the international medical community. This includes any of the above which are undergoing study, research, testing or are at any stage of clinical experimentation.

Further

Further Underwriting International SLU. It is a company which specialises in the development of both insurance products and the management of overseas treatment for serious medical conditions. Further Underwriting International SLU. at C/ Hortaleza 104, 28004, Madrid, Spain, registered in the Mercantile Registry in Madrid under hoja m-327635, tomo 18794, folio 76 and tax number (CIF) ESB83644484.

Medically necessary

Health care services and supplies which are:

- necessary to meet your, or your **child's** basic health needs; and
- given in the most medically appropriate manner and type of setting appropriate for the delivery of the health service, taking into account both cost and quality of care; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines of medical, research or health care coverage organisations or governmental agencies that are accepted by **Further**, and
- consistent with the diagnosis of the condition or illness; and
- required for reasons other than the convenience of you, your **child** or **consultant**; and
- demonstrated through prevailing pre-reviewed medical literature to be either:
  - effective for treating or diagnosing the condition or illness for which its use is proposed; or
  - efficient for treating a life threatening condition or illness in a clinically controlled research setting.

Medical procedure

A **medical procedure** which we cover in this global treatment option.

Medication

Any single substance or combination of substances, which may be used or administered to you or your **child** with a view to restoring, correcting or modifying physiological functions.

Preliminary medical certificate

Written approval relating to a claim issued by **Further** and/or us before giving any treatment, services, supplies or prescriptions. The **preliminary medical certificate** will include confirmation of your global treatment benefit and the hospital outside of the **territory** authorised for your, or your **child's** treatment.

Prosthesis

A device which replaces all or part of an organ, or replaces all or part of the function of an inoperative or malfunctioning part of the body.

Reconstructive surgery

Procedures that are intended to rebuild a structure to correct its loss of function where **medically necessary,** exclusively when the structure has been damaged or removed.

Renewal date

The third anniversary of the **start date** and the **end date** of every following three year period.

Resident

At the time you apply for this policy you must:

1. be currently physically living in the UK, the Channel Islands, the Isle of Man or Gibraltar, and
2. regard the UK, the Channel Islands, the Isle of Man or Gibraltar as the location of your main residence, and have no current intention of moving outside of any of those territories permanently, and

3. either
    a. be a citizen of that territory or a British Overseas Territories citizen, or
    b. have been granted permission to settle permanently in the named territory, or
    c. be applying for a mortgage on a residential property which is, or will be, your main residence in that territory.

You need to tell us if you move outside of the UK, the Channel Islands, Isle of Man or Gibraltar, and your main residence is in another territory. We may need to change, reduce or remove any of your policy terms. We'll give you details once you've told us. You should seek your own independent advice if you wish to continue with your policy after you move to another territory.

Second opinion

A structured second medical opinion, based on an in-depth review of the medical information relating to you or your **child**. This service is provided by **Best Doctors**.

Serious illness

A **serious illness** which we cover in this global treatment option.

Surgery

All operations with a diagnostic or therapeutic purpose, carried out through incision or other means of internal entry, by a **consultant** at a hospital and which normally requires the use of an operating theatre.

Territory

England, Northern Ireland, Scotland, Wales, Jersey, Guernsey, the Isle of Man and Gibraltar.

Travelling companion

The person you choose to accompany you or your **child** while travelling and receiving treatment overseas.

Appendices

We cover a number of types of conditions, illnesses and treatments. This table sets out which appendices you should refer to for each of type of condition, illness or treatment.

	Appendix 1A	Appendix 1B	Appendix 2A	Appendix 2B	Appendix 3A	Appendix 3B
Critical Illness	✓					
Accelerated surgery benefit	✓					
Additional critical illness		✓				
Children's critical illness	✓	✓				
Upgraded critical illness conditions	✓		✓			
Upgraded additional critical illness				✓		
Upgraded accelerated surgery benefit	✓		✓			
Upgraded children's critical illness	✓	✓			✓	
Child extra care cover						✓

Appendix 1 A – Main benefits under critical illness cover

Critical illnesses

Below you'll find a list of each of the illnesses or conditions we cover under critical illness benefit and under **children's benefit**.

We also cover definitions marked with a* under accelerated surgery benefit and upgraded accelerated surgery benefit.

For each critical illness listed in alphabetical order below, we have set out the definition we'll use when we're assessing a claim.

Aorta graft surgery*

The undergoing of surgery to the aorta with excision and surgical replacement of a portion of the affected aorta with a graft. The term aorta includes the thoracic and abdominal aorta, but not its branches.

The following are not covered:

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

Aplastic anaemia – with bone marrow failure

A definite diagnosis of aplastic anaemia by a consultant haematologist. There must be permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia.

Bacterial meningitis – resulting in permanent symptoms

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit with persisting clinical symptoms. The diagnosis must be confirmed by a consultant neurologist.

The following are not covered:

- all other forms of meningitis including viral meningitis.

Benign brain tumour – resulting in permanent symptoms or undergoing defined treatments

A non-malignant tumour or cyst originating in the brain, cranial nerves or meninges within the skull, resulting in any of the following:

- permanent neurological deficit with persisting clinical symptoms; or
- undergoing invasive surgery to remove part or all of the tumour; or
- undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells.

The following are not covered:

- tumours in the pituitary gland
- angiomas.

Blindness – permanent and irreversible

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 6/60 or worse in the better eye using a Snellen eye chart or visual field is reduced to 20 degrees or less of an arc, certified by an ophthalmologist.

Brain injury due to anoxia or hypoxia – resulting in permanent symptoms

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

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
- lymphoma (except cutaneous lymphoma – lymphoma confined to the skin)
- pseudomyxoma peritonei
- Merkel cell cancer

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 T2bN0M0
- malignant melanoma skin cancer that is confined to the epidermis (outer layer of skin)
- any non-melanoma skin cancer or cutaneous lymphoma unless it has spread to lymph nodes or distant organs.

Cardiac arrest – with insertion of a defibrillator

Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and either of the following devices being surgically implanted:

- implantable cardioverter-defibrillator (ICD); or
- cardiac resynchronisation therapy with defibrillator (CRT-D).

Coma – with associated permanent symptoms

A state of unconsciousness with no reaction to external stimuli or internal needs which:

- requires the use of life support systems; and
- results in associated permanent neurological deficit with persisting clinical symptoms.

Coronary artery bypass graft*

The undergoing of surgery on the advice of a consultant cardiologist to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

Creutzfeldt-Jakob disease

A definite diagnosis of Creutzfeldt-Jakob disease by a consultant neurologist.

Deafness – permanent and irreversible

Permanent and irreversible loss of hearing to the extent that the quietest sound that can be heard in the better ear is 70 decibels across all frequencies using a pure tone audiogram.

Dementia – resulting in permanent symptoms

A definite diagnosis of dementia including 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; and
- reason; and
- perceive, understand, express and give effect to ideas.

Encephalitis – resulting in permanent symptoms

A definite diagnosis of encephalitis by a consultant neurologist resulting in permanent neurological deficit with persisting clinical symptoms.

Heart attack

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- new characteristic electrocardiographic changes or other positive findings on diagnostic imaging tests
- the characteristic rise of cardiac enzymes or Troponins.

The evidence must show a definite acute myocardial infarction. The following are not covered:

- other acute coronary syndromes
- angina without myocardial infarction.

Heart valve replacement or repair*

The undergoing of surgery on the advice of a consultant cardiologist to replace or repair one or more heart valves.

Kidney failure – requiring permanent dialysis

Chronic and end stage failure of both kidneys to function as a result of which regular dialysis is permanently required.

Liver failure

Chronic liver disease, being end stage liver failure due to cirrhosis and resulting in all of the following:

- permanent jaundice
- ascites
- encephalopathy.

Loss of hand or foot – permanent physical severance

Permanent physical severance of a hand or foot at or above the wrist or ankle joint.

Major organ transplant* – from another donor where applicable

The undergoing as a recipient a transplant of:

- bone marrow; or
- haematopoietic stem cells preceded by total bone marrow ablation; or
- a complete heart, kidney, liver, lung, or pancreas from another donor; or
- a whole lobe of the lung or liver from another donor; or
- inclusion on an official UK waiting list for such a procedure.

The following is not covered:

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

Motor neurone disease – resulting in permanent symptoms

A definite diagnosis of one of the following motor neurone diseases by a consultant neurologist:

- amyotrophic lateral sclerosis (ALS)
- Kennedy's disease
- primary lateral sclerosis (PLS)
- progressive bulbar palsy (PBP)
- progressive muscular atrophy (PMA)
- spinal muscular atrophy (SMA).

There must also be permanent clinical impairment of motor function.

Multiple sclerosis – where there have been symptoms

A definite diagnosis of multiple sclerosis by a consultant neurologist. There must have been clinical impairment of motor or sensory function caused by multiple sclerosis.

Paralysis of a limb – total and irreversible

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

Parkinson's disease – resulting in permanent symptoms

A definite diagnosis of Parkinson's disease by a consultant neurologist or geriatrician. There must be permanent clinical impairment of motor function with associated tremor or muscle rigidity.

The following are not covered:

- Parkinsonian syndromes
- Parkinsonism.

Primary cardiomyopathy – of specified severity or undergoing a defined treatment

A definite diagnosis of primary cardiomyopathy by a consultant cardiologist. The disease must result in at least one of the following:

- left ventricular ejection fraction (LVEF) of less than 40% measured twice at an interval of at least 3 months by an MRI scan
- marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain (Class III or IV of the New York Heart Association classification) over a period of at least 6 months
- implantation of a cardioverter defibrillator (ICD) on the specific advice of a consultant cardiologist for the prevention of sudden cardiac death.

The following are not covered:

- any secondary cardiomyopathy
- all other forms of heart disease, heart enlargement and myocarditis.

Pulmonary arterial hypertension – of specified cause and severity

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

- idiopathic pulmonary arterial hypertension
- chronic thrombo-embolic pulmonary hypertension.

There must be all of the following:

- a systolic pulmonary arterial pressure (PAP) of greater than 50mmHg (mm of mercury) for more than a year
- permanent and irreversible right ventricular dilatation and hypertrophy on echocardiogram and electrocardiogram (ECG).

Pulmonary artery surgery*

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) or thoracotomy on the advice of a consultant cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

Respiratory failure – of specified severity

Confirmation by a consultant physician of severe lung disease with permanent impairment of lung function resulting in all of the following:

- the need for daily oxygen therapy for a minimum of 15 hours per day for at least six months
- forced expiratory volume at 1 second (FEV1) below 50% of normal
- forced vital capacity (FVC) below 50% of normal.

Spinal stroke

Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal column resulting in either:

- permanent neurological deficit with persisting clinical symptoms; or
- definite evidence of death of spinal cord tissue or haemorrhage within the spinal column on a relevant scan and neurological deficit with persistent clinical symptoms lasting at least 24 hours.

The following is not covered:

- transient ischaemic attacks (TIA)

Stroke

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in either:

- permanent neurological deficit with persisting clinical symptoms; or
- definite evidence of death of tissue or haemorrhage on a brain scan and neurological deficit with persistent clinical symptoms lasting at least 24 hours.

The following are not covered:

- transient ischaemic attacks (TIA)
- death of tissue of the optic nerve or retina/eye stroke.

Structural heart surgery*

The undergoing of heart surgery requiring median sternotomy (surgery to divide the breast bone) or thoracotomy on the advice of a consultant cardiologist to correct any structural abnormality of the heart.

Systemic lupus erythematosus – of specified severity

A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist resulting in either of the following:

- permanent neurological deficit with persisting clinical symptoms; or
- permanent impairment of kidney function with glomerular filtration rate (GFR) below 30 ml/min.

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; and
- in the opinion of the **attending consultant**, the illness is expected to lead to death within 12 months

Third degree burns – of specified severity

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area or covering at least 20% of the surface area of the face or head.

Traumatic brain injury – resulting in permanent symptoms

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

Appendix 1 B – Additional benefits under critical illness cover

Additional critical illness

Below is a list of each of the additional critical illnesses we cover. These conditions are also included under **children's benefit.** For each additional critical illness, we have set out the definition we'll use when we're assessing a claim.

Less advanced cancer of the breast – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ or neuroendocrine tumour (NET) of low malignant potential of the breast with surgery to remove the tumour.

Less advanced cancer of the prostate – of specified severity and treatment

Tumours of the prostate histologically classified as having a Gleason score between 2 and 6 inclusive providing the tumour has progressed to a clinical TNM classification between T1N0M0 and T2aN0M0 and the tumour has been treated by one of the following:

- complete removal of the prostate
- external beam or interstitial implant therapy
- cryotherapy
- hormone therapy
- high intensity focused ultrasound.

The following is not covered:

- prostate cancers where the treatment is not one of the specified treatments above, or requires observation only.

Appendix 2 A – Upgraded critical illness benefit

Upgraded critical illness benefit

This includes all of the critical illnesses covered in Appendix 1A, together with the upgraded critical illnesses listed below.

We also cover the definitions marked with a* under upgraded accelerated surgery benefit. For accelerated surgery benefit, the definitions marked with a* in Appendix 1A also apply.

For each of the upgraded critical illnesses listed in alphabetical order below, we have set out the definition we'll use when we're assessing a claim.

Benign spinal cord tumour - resulting in permanent symptoms or undergoing specified treatments

A non-malignant tumour or cyst in the spinal cord, spinal nerves or meninges, resulting in any of the following:

- permanent neurological deficit with persisting clinical symptoms; or
- undergoing invasive surgery to remove part or all of the tumour; or
- undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells.

The following are not covered:

- granulomas, haematomas, abscesses, disc protrusions and osteophytes.

Brain abscess – undergoing defined treatments

A definite diagnosis of an intracerebral abscess within the brain tissue by a consultant neurologist, resulting in either of the following:

- surgical removal; or
- surgical drainage of the abscess.

Crohn's disease – treated with two intestinal resections or total colectomy

A definite diagnosis by a consultant gastroenterologist of Crohn's disease, resulting in either:

- surgical intestinal resection to remove part of the small intestine or bowel on at least two separate occasions; or
- total colectomy (removal of entire large bowel).

Heart failure – of specified severity

A definite diagnosis by a consultant cardiologist of failure of the heart to function as a pump which is evidenced by all of the following:

- permanent and irreversible limitation of function to at least class III on the New York Heart Association (NYHA) classification of functional capacity (ie. heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitations, breathlessness or chest pain)
- permanent and irreversible ejection fraction of 39% or less.

Intensive care – requiring mechanical ventilation for 10 consecutive days

Any sickness or injury resulting in the **life 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.

Interstitial lung disease – of specified severity

A definite diagnosis of interstitial lung disease by a consultant respiratory physician resulting in all of the following:

- radiological evidence of pulmonary fibrosis
- permanent and irreversible DLCO (diffusing capacity of the lung for carbon monoxide) below 40% of predicted.

Neuromyelitis optica (Devic's disease) – where there have been symptoms

A definite diagnosis of neuromyelitis optica (Devic's disease) by a consultant neurologist. There must have been clinical impairment of motor or sensory function caused by neuromyelitis optica.

The following is not covered:

- neuromyelitis optica spectrum disorder.

Parkinson's plus syndromes – resulting in permanent symptoms

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

- multiple system atrophy
- progressive supranuclear palsy
- Parkinsonism-dementia-ALS complex
- diffuse lewy body disease
- corticobasal degeneration.

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

- motor function; or
- eye movement disorder; or
- postural instability; or
- dementia.

The following are not covered:

- other Parkinsonian syndromes
- Parkinsonism.

Peripheral vascular disease* – requiring bypass surgery

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 bypass graft surgery to an artery of the legs.

The following is not covered:

- angioplasty.

Pneumonectomy*

The undergoing of surgery on the advice of a consultant medical specialist to remove an entire lung due to disease or traumatic injury.

The following is not covered:

- other forms of surgery to the lungs including removal of a lobe of the lungs (lobectomy) or lung resection.

Psychosis and bipolar affective disorder – of specified severity

A definite diagnosis by a consultant psychiatrist of any of the following:

- bipolar affective disorder; or
- paranoid (delusional) psychosis; or
- schizo-affective disorder; or
- schizophrenia,

which has resulted in at least three of the following occurring within one year:

- being under the care of a psychiatrist, psychiatric nurse, community mental health team or approved social worker
- chronic symptoms lasting at least a year or requiring continuous therapy or medication to control them
- in patient admission to a psychiatric ward for at least 14 consecutive nights
- a court order being made by the Court of Protection under the Mental Capacity Act.

The following are not covered:

- delirium where there is no underlying psychiatric disorder
- conditions caused by or exacerbated by alcohol or drug misuse.

Rheumatoid arthritis – of specified severity

Severe chronic rheumatoid arthritis evidenced by widespread joint destruction and deformity of at least three major joint groups, resulting in the inability to do three of the following:

- bend or kneel to pick up an object from the floor
- use hands or fingers to pick up or manipulate small objects such as cutlery or a pen
- lift or carry an everyday object such as a kettle
- walk a distance of 200m on flat ground with or without the use of a walking stick and without experiencing severe discomfort.

Syringomyelia or syringobulbia* – requiring surgery

The undergoing of surgery to treat a syrinx in the spinal cord or brain stem.

Ulcerative colitis* – with total colectomy

A definite diagnosis of ulcerative colitis by a consultant gastroenterologist, which is treated with total colectomy (removal of entire large bowel).

Appendix 2 B – Upgraded additional critical illness benefit

Upgraded additional critical illness

Instead of the additional critical illnesses listed in Appendix 1B, we'll cover the following upgraded additional critical illnesses. For each of the upgraded additional critical illnesses listed in alphabetical order below, we have set out the definition we'll use when we're assessing a claim.

Aortic aneurysm – with endovascular repair

The undergoing of endovascular repair of an aneurysm of the thoracic or abdominal aorta with a graft.
The following is not covered:

- procedures to any branches of the thoracic or abdominal aorta.

Aplastic anaemia – of specified severity

A definite diagnosis of aplastic anaemia by a consultant haematologist. There must be bone marrow hypocellularity confirmed by biopsy with at least two of the following:

- absolute neutrophil count (ANC) <0.5 x 10^9/L
- platelet count <20 x 10^9/L
- Hb <100 g/L (<10g/dL)

The following is not covered:

- other types of anaemia.

Carotid artery stenosis – with surgical repair

The undergoing of endarterectomy or angioplasty with or without stent on the advice of a consultant physician to treat severe symptomatic stenosis in a carotid artery. This operation must be to treat:

- at least 50% diameter narrowing; and
- angiographic evidence will be required.

Cauda equina syndrome – with permanent symptoms

Compression of the lumbosacral nerve roots (cauda equina) resulting in all of the following:

- permanent bladder dysfunction; and
- permanent weakness and loss of sensation in the legs.

The diagnosis must be supported by appropriate neurological evidence.

Central retinal artery or vein occlusion – with permanent visual impairment

Death of the 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.

The following are not covered:

- branch retinal artery or vein occlusion or haemorrhage
- traumatic injury to tissue of the optic nerve or retina.

Cerebral or spinal aneurysm – with specified surgery

The undergoing of either of the following surgical procedures:

- surgical correction via craniotomy (surgical opening of the skull) or embolisation treatment using coils or other materials, in order to treat a cerebral aneurysm; or
- surgical resection, wrapping, clipping or embolisation of a spinal aneurysm.

Cerebral or spinal arteriovenous malformation – with specified surgery

The undergoing of either of the following surgical procedures:

- surgical correction via craniotomy (surgical opening of the skull) or endovascular treatment using coils or other materials, in order to treat a cerebral arteriovenous malformation; or
- surgical correction or embolisation of a spinal arteriovenous malformation.

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 for 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.

Crohn's disease – treated with one intestinal resection

A definite diagnosis by a consultant gastroenterologist of Crohn's disease, which has been treated with surgical intestinal resection.

Diabetes mellitus type 1

A definite diagnosis of type 1 diabetes mellitus, requiring the permanent use of insulin injections. The following are not covered:

- gestational diabetes
- type 2 diabetes (including type 2 diabetes treated with insulin).

Drug resistant epilepsy – with specified surgery

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

The following is not covered:

- deep brain stimulation.

Guillain-Barre syndrome – with persisting clinical symptoms

A definite diagnosis of Guillain-Barre syndrome by a consultant neurologist. There must be clinical impairment of motor or sensory function which must have persisted for a continuous period of at least six months.

Less advanced cancer of the anus – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ of the anus with surgery to remove the tumour.

The following are not covered:

- anal intraepithelial neoplasia (AIN) grade 1 or 2, or low grade squamous intraepithelial lesions (LGSIL)
- all non-surgical therapies which include but are not limited to all forms of ablative therapy and topical therapy.

Less advanced cancer of the appendix, colon or rectum – with specified surgery

A positive diagnosis with histological confirmation of cancer in situ or neuroendocrine tumour (NET) of low malignant potential of the appendix, colon or rectum resulting in surgery to remove a portion of the colon, rectum or appendix.

Less advanced cancer of the bile ducts – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ of the extra-hepatic bile ducts with surgery to remove the tumour.

Less advanced cancer of the breast – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ or neuroendocrine tumour (NET) of low malignant potential of the breast with surgery to remove the tumour.

Less advanced cancer of the cervix – with specified surgery

A positive diagnosis with histological confirmation of cancer in situ of the cervix uteri resulting in trachelectomy (removal of the cervix) or hysterectomy.

The following are not covered:

- loop excision
- laser surgery
- conisation
- cryosurgery
- cervical intraepithelial neoplasia (CIN) grade I or II, or low grade squamous intraepithelial lesions (LGSIL).

Less advanced cancer of the gallbladder – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ of the gallbladder with surgery to remove the tumour.

Less advanced cancer of the larynx – with specified treatment

A positive diagnosis with histological confirmation of cancer in situ of the larynx treated with surgery, laser or radiotherapy.

Less advanced cancer of the lung or bronchus – with specified surgery

A positive diagnosis with histological confirmation of any of the following tumours of the lung or bronchus resulting in wedge resection or lobectomy:

- cancer in situ; or
- neuroendocrine tumour (NET) of low malignant potential; or
- carcinoid tumour.

Less advanced cancer of the oesophagus – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ of the oesophagus with surgery to remove the tumour.

Less advanced cancer of the oral cavity or oropharynx – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ of the oral cavity or oropharynx with surgery to remove the tumour.

This includes lips, inside of the cheeks, floor of the mouth, tongue, gums, hard palate, soft palate and tonsils.

Less advanced cancer of the ovary – with surgical removal

A positive diagnosis with histological confirmation of ovarian tumour of borderline malignancy or low malignant potential which has resulted in surgical removal of an ovary.

The following is not covered:

- removal of an ovary due to a cyst.

Less advanced cancer of the pancreas – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ or neuroendocrine tumour (NET) of low malignant potential of the pancreas with surgery to remove the tumour.

Less advanced cancer of the prostate – of specified severity and treatment

Tumours of the prostate histologically classified as having a Gleason score between 2 and 6 inclusive providing the tumour has progressed to a clinical TNM classification between T1N0M0 and T2aN0M0 and the tumour has been treated by one of the following:

- complete removal of the prostate
- external beam or interstitial implant therapy

- cryotherapy
- hormone therapy
- high intensity focused ultrasound.

The following is not covered:

- prostate cancers where the treatment is not one of the specified treatments above, or requires observation only.

Less advanced cancer of the renal pelvis or ureter – of specified severity

A positive diagnosis with histological confirmation of cancer in situ of the renal pelvis or ureter. The following are not covered:

- non-invasive papillary carcinoma
- tumours of TNM classification stage Ta.

Less advanced cancer of the small intestine – with specified surgery

A positive diagnosis with histological confirmation of neuroendocrine tumour (NET) of low malignant potential of the duodenum, jejunum or ileum resulting in intestinal resection.

Less advanced cancer of the stomach – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ or neuroendocrine tumour (NET) of low malignant potential of the stomach with surgery to remove the tumour.

Less advanced cancer of the testicle – with specified surgery

A positive diagnosis with histological confirmation of intra-tubular germ cell neoplasia unclassified (ITGCNU) or benign testicular tumour resulting in orchidectomy (removal of a testicle).

Less advanced cancer of the thymus – with surgical removal

A positive diagnosis with histological confirmation of epithelial tumour (thymoma) or neuroendocrine tumour (NET) of low malignant potential of the thymus with surgery to remove the tumour.

Less advanced cancer of the thyroid – with surgical removal

A positive diagnosis with histological confirmation of neuroendocrine tumour (NET) of low malignant potential of the thyroid with surgery to remove the tumour.

Less advanced cancer of the urinary bladder – of specified severity

A positive diagnosis with histological confirmation of cancer in situ of the urinary bladder. The following are not covered:

- non-invasive papillary carcinoma
- TNM classification stage Ta bladder cancer.

Less advanced cancer of the uterus – with specified surgery

A positive diagnosis with histological confirmation of cancer in situ of the lining of the uterus (endometrium) resulting in hysterectomy.

Less advanced cancer of the vagina – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ of the vagina resulting in surgery to remove the tumour.

The following are not covered:

- all non-surgical therapies which include but are not limited to all forms of ablative therapy and topical therapy
- vaginal intraepithelial neoplasia (VAIN) grade 1 or 2 or low grade squamous intraepithelial neoplasia.

Less advanced cancer of the vulva – with surgical removal

A positive diagnosis with histological confirmation of cancer in situ of the vulva resulting in surgery to remove the tumour.

The following are not covered:

- all non-surgical therapies which include but are not limited to all forms of ablative therapy and topical therapy
- vulval intraepithelial neoplasia (VIN) grade 1 or 2 or low grade squamous intraepithelial neoplasia.

Non-malignant pituitary adenoma – with specified treatment

A non-malignant pituitary tumour requiring radiotherapy or surgical removal. The following is not covered:

- non-malignant tumours of the pituitary gland treated by any other method.

Removal of one or more lobe(s) of the lung

The undergoing of surgery for the removal of one or more lobes of the lung due to underlying disease or trauma. The surgery must be carried out on the advice of a consultant physician.

Significant visual loss – permanent and irreversible

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids vision is measured at 6/24 or worse in the better eye using a Snellen eye chart, or visual field is reduced to 45 degrees or less of an arc, as certified by an ophthalmologist.

Third degree burns – covering at least 5% of the body's surface area or 10% of the face or head

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% of the body's surface area or covering at least 10% of the surface area of the face or head.

Appendix 3 A –
Upgraded children's benefit

Upgraded children's critical illnesses

This includes all of the critical illnesses covered in Appendix 1A and 1B, together with the upgraded children's critical illnesses listed below. For each upgraded children's critical illness or condition listed in alphabetical order below, we have set out the definition we'll use when we're assessing a claim.

Benign spinal cord tumour – resulting in permanent symptoms or undergoing specified treatments

A non-malignant tumour or cyst in the spinal cord, spinal nerves or meninges, resulting in any of the following:

- permanent neurological deficit with persisting clinical symptoms; or
- undergoing invasive surgery to remove part or all of the tumour; or
- undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells.

The following are not covered:

- granulomas, haematomas, abscesses, disc protrusions and osteophytes.

Brain abscess – undergoing defined treatments

A definite diagnosis of an intracerebral abscess within the brain tissue by a consultant neurologist, resulting in either of the following:

- surgical removal; or
- surgical drainage of the abscess.

Cerebral palsy

A definite diagnosis of cerebral palsy made by an **attending consultant**.

Crohn's disease – treated with two intestinal resections or total colectomy

A definite diagnosis by a consultant gastroenterologist of Crohn's disease, resulting in either:

- surgical intestinal resection to remove part of the small intestine or bowel on at least two separate occasions; or
- total colectomy (removal of entire large bowel).

Cystic fibrosis

A definite diagnosis of cystic fibrosis made by an **attending consultant**.

Diabetes mellitus type 1

A definite diagnosis of type 1 diabetes mellitus, requiring the permanent use of insulin injections.

The following are not covered:

- gestational diabetes
- type 2 diabetes (including type 2 diabetes treated with insulin).

Down's syndrome

A definite diagnosis of Down's syndrome by an attending paediatrician.

Hydrocephalus – treated with the insertion of a shunt

A definite diagnosis of hydrocephalus which is treated by the insertion of a shunt.

Intensive care – requiring mechanical ventilation for 7 consecutive days

Any sickness or injury resulting in a **child** requiring continuous mechanical ventilation by means of tracheal intubation for 7 consecutive days (24 hours per day) or more unless it is as a result of the **child** being born prematurely (before 37 weeks).

Third degree burns – covering at least 5% of the body's surface area or 10% of the face or head

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% of the body's surface area or covering at least 10% of the surface area of the face or head.

Ulcerative colitis – with total colectomy

A definite diagnosis of ulcerative colitis by a consultant gastroenterologist, which is treated with total colectomy (removal of entire large bowel).

Appendix 3 B –
Upgraded children's benefit

Child extra care cover

We'll pay for the following child extra care cover conditions:

Blindness – permanent and irreversible

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 6/60 or worse in the better eye using a Snellen eye chart or visual field is reduced to 20 degrees or less of an arc, certified by an ophthalmologist.

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
- lymphoma (except cutaneous lymphoma - lymphoma confined to the skin)
- pseudomyxoma peritonei
- Merkel cell cancer

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 T2bN0M0
- malignant melanoma skin cancer that is confined to the epidermis (outer layer of skin)
- any non-melanoma skin cancer or cutaneous lymphoma unless it has spread to lymph nodes or distant organs.

Kidney failure – requiring permanent dialysis

Chronic and end stage failure of both kidneys to function as a result of which regular dialysis is permanently required.

Liver failure

Chronic liver disease, being end stage liver failure due to cirrhosis and resulting in all of the following:

- permanent jaundice
- ascites
- encephalopathy.

Loss of independence

The total and permanent loss of the ability to perform routinely at least two of the specified six activities of daily living without the continual assistance of someone else, even with the use of special devices or equipment.

The following are activities of daily living:

- Washing – this means being able to wash and bathe unaided, including getting into and out of the bath or shower.
- Dressing – this means being able to put on, take off, secure and unfasten all necessary items of clothing.
- Feeding – this means being able to eat pre-prepared foods unaided.
- Continence – this means being able to control bowel or bladder functions, whether with or without the use of protective undergarments and surgical appliances.
- Moving – this means being able to move from one room to another on level surfaces.
- Transferring – this means being able to get on and off the toilet, in and out of bed and move from a bed to an upright chair or wheelchair and back again.

The loss of independence must be entirely due to illness or injury, and not as a result of the age of the **child**. Having met our definition, the **child** must survive for 90 days.

Loss of two limbs – permanent physical severance

Permanent physical severance of any two limbs at or above the wrist or ankle joint.

Major organ transplant – from another donor where applicable

The undergoing as a recipient a transplant of:

- bone marrow; or
- haematopoietic stem cells preceded by total bone marrow ablation; or
- a complete heart, kidney, liver, lung, or pancreas from another donor; or
- a whole lobe of the lung or liver from another donor; or
- inclusion on an official UK waiting list for such a procedure.

The following is not covered:

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

Motor neurone disease – resulting in permanent symptoms

A definite diagnosis of one of the following motor neurone diseases by a consultant neurologist:

- amyotrophic lateral sclerosis (ALS)
- Kennedy's disease
- primary lateral sclerosis (PLS)
- progressive bulbar palsy (PBP)
- progressive muscular atrophy (PMA)
- spinal muscular atrophy (SMA).

There must also be permanent clinical impairment of motor function.

Muscular dystrophy

A definite diagnosis of muscular dystrophy made by a consultant neurologist.

Paralysis of two limbs – total and irreversible

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

Spina bifida myelomeningocele

A definite diagnosis of spina bifida myelomeningocele or rachischisis by a consultant paediatrician.

The following are not covered:

- spina bifida occulta
- spina bifida with meningocele.

Third degree burns – of specified severity

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area or covering at least 20% of the surface area of the face or head.

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