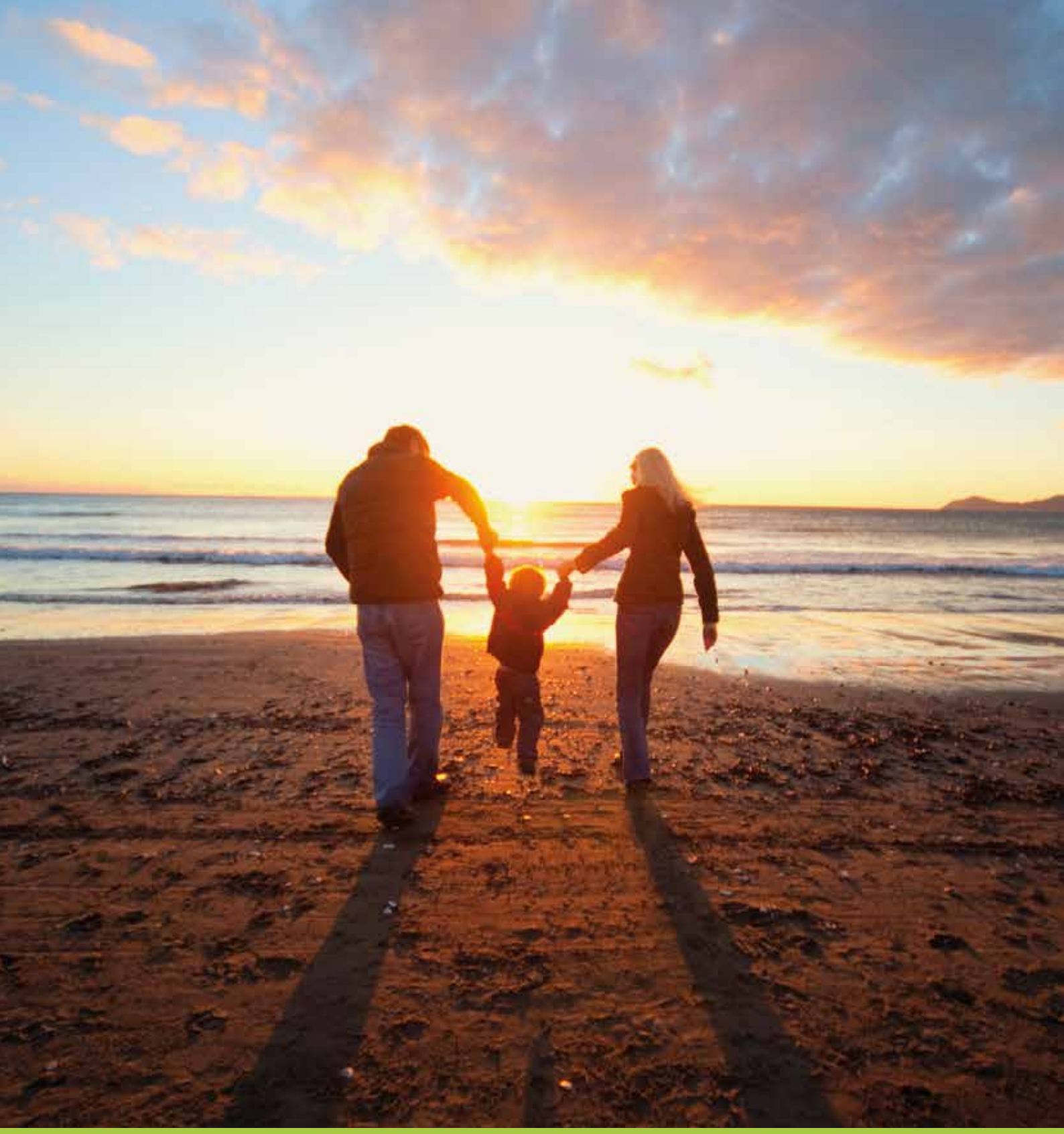
yourchoice

Health Insurance

Effective from 1st March 2018

CS healthcare



" Always helpful, understanding and aware that you may be going through a stressful time. Very positive and reassuring. Always feels we are with the best provider."

Mrs C Donaldson-Badger

Contents

The reassurance of private health insurance

Choosing the right health insurance can be difficult. With so many insurers and options to choose from, you want to make the right choice – the right level of protection at the right price.

Everybody has different needs, which is why CS Healthcare offers a selection of cover so you can choose what best suits you and your budget – it's an affordable and flexible way to help cover the cost of private medical treatment.

While the NHS can provide an excellent service, waiting times to see a Consultant and to receive any subsequent medical treatment can be unpredictable. Most modern medical procedures can cost a considerable amount. For example, heart bypass surgery can cost £25,300¥ and a hip replacement can cost approximately £14,050¥.

With CS Healthcare you can rest assured that the cost of treatment is covered for eligible new medical conditions arising after your cover begins. There's also the peace of mind that you and your family will be treated in a clean, safe and private environment especially designed to speed up recovery.

Key benefits of our health insurance

- fast access to medical treatment
- access to over 300 hospitals across the UK
- competitive rates from a mutual health insurer
- fast, direct claim settlement with expertise and guidance at every stage
- flexible choice of cover, designed to suit your needs and budget
- fair pricing - we don't penalise you individually for making a claim

¥Source: Nuffield Tariff 2016. Includes surgeon and anaesthetist fees

Quality cover that's got everyone talking

94%

*of existing members would recommend our service**

So why is it that people choose CS Healthcare? For a start 94% of existing members would recommend our service to friends and family*.

An enviable figure and one we have gained for good reason. While members join for the price, they stay for the service – a staggering 95% of new members rate our service as excellent or good†. We're a Friendly Society, run for the benefit of our members and it does make a difference. We pride ourselves on providing a high level of personal service and it is this service that gives you access to experienced UK based staff, who are dedicated to helping you.

Proud to be mutual

We stand apart from many of our competitors as a mutual friendly society, established to protect our members. Our mutual status means we just look after members and, unlike some commercial insurers we do not have any shareholders.

Who can join?

If you work, or have worked, in any of the sectors below you and your family are eligible to join CS Healthcare:

- civil service
- public service
- privatised organisations (former public sector)
- charities
- armed forces
- not-for-profit-organisations
- voluntary sectors

The minimum age for a policy holder to join CS Healthcare is 18 years and the maximum age to join is 74 years and 11 months.

* CS Healthcare member surveys for existing members carried out between January to June 2017
† CS Healthcare member surveys for new members carried out between July 2015 to December 2016

Health insurance, plus personal support to see you through

When you join CS Healthcare you'll notice an important difference – we treat you as an individual rather than simply a policyholder. As a dedicated and specialist health insurer we have been looking after our members for over 80 years. We pride ourselves on the personal service we provide to all our members.

We take the worry out of making a claim for our members – 90% rate our claims service highly[§]. If you think you need to see a Specialist or if you know that you are going to need treatment, simply contact our Claims Helpline first and one of our claims advisers will talk you through the process step by step. Our UK based advisers are available from 8am to 6pm, Monday to Friday. And, once you've received your treatment, we'll arrange to settle your bills direct with the hospital or consultant.

In addition to our Claims Helpline all members have access to Lifeline 24 hours a day, 7 days a week. This service is staffed by experienced registered nurses who are trained to provide advice and assistance across a range of medical issues.

Benefits include:

- a Nurse Adviser on call 24 hours a day
- Doctor call back service at a time convenient to you
- direct advice on medical issues
- no limit to the number of times you can call

Member rewards

Being a member of CS Healthcare entitles you to take advantage of a range of discounted offers, including;

- gym membership
- health screenings
- travel insurance
- home insurance

90%
rate our claims service highly[§]

[§] CS Healthcare Claims Department surveys carried out between January to December 2016

You decide – it's your choice

We recognise that everyone has different needs and that circumstances change over time. That's why with your choice health insurance we offer a menu of cover options so that you can create your own package of health protection. You build your health plan depending on how much cover you feel you require and how much you want to spend.

Starting with Essential cover for in-patient/day-patient treatment, including specialised scans and necessary aftercare, you can select further options to extend your plan to include diagnostic consultations, a range of therapy and recovery care, heart and cancer treatment and also cash benefits for dental, optical and health screening. You have the choice of reviewing your cover at each renewal to make adjustments to your cover options, within policy terms and conditions.

As well as the flexibility to pick and choose the cover that meets the needs of you and your family, there are also many ways in which you can further reduce your premium. We offer a range of voluntary excess options designed to reduce premiums by up to 60% or you can choose one of our co-payment options, where you agree to pay a proportion of each claim, but only up to an agreed limit.

And if you're insuring your family, you pay nothing for children under 1 year old, and your eldest child under 18 years of age can be included on your policy absolutely FREE.

Building your cover

The your choice health plan offers flexible health insurance, allowing you to select from a range of benefit options to create your own personalised plan.

There is one compulsory level of cover, Essential, which includes hospital stays, specialised scans and surgery. You can then choose to take out additional cover for heart and cancer treatment, out-patient consultations, therapies, as well as additional cash benefits.

Essential

the foundation of your health plan

This is the only part of your choice which we have made compulsory. The Essential plan provides cover at great value, leaving you to decide if you wish to increase cover further with additional options.

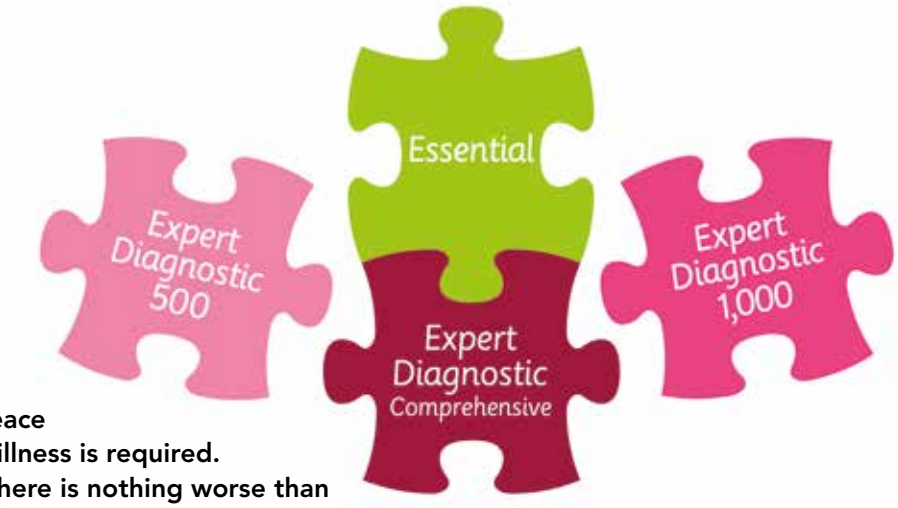
By itself, Essential offers a core level of coverage for surgery, accommodation, and specialised scans, including MRI, CT and PET scans. There's also cover for pre and post-operative tests to help ensure recovery is smooth and free from complications.

Here's a summary to help explain what's included:

- surgical admissions and related hospital charges
- medical admission and related services
- Specialist/Consultant fees for medical admissions
- specialised scans
- Surgeon and Anaesthetist fees as per fee schedule
- out-patient surgery and related charges
- pre-operative tests to assess your fitness for surgery
- post-operative consultations, investigations, tests and physiotherapy within a 90 day period immediately following a hospital admission
- private road ambulance – up to £250 per person per policy year
- nursing at home or convalescence benefit - up to a maximum of 14 days and £2,800 each admission immediately following a hospital admission either as an NHS or private patient under the specific direction of a Specialist/ Consultant.
- parent accommodation
- NHS cash allowance – £150 each night or day case admission up to 28 nights inclusive of day case admissions (up to a maximum of £4,200) per person per policy year for eligible claims under this option
- Discretionary Your Care Package
- Lifeline – health advice line with Doctor call back service

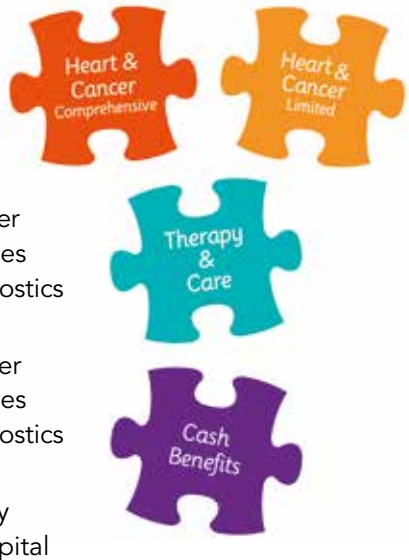
Expert Diagnostics options

fast access to initial consultations



Our Expert Diagnostics options give you peace of mind when investigation for an injury or illness is required. When you think something may be wrong there is nothing worse than having to wait for those all important out-patient tests or consultations.

Choose from 3 different levels of cover for Expert Diagnostics (for further details please refer to the schedule of benefits on page 20):



- Expert Diagnostics Comprehensive (includes £1,000 psychiatric cover),
- Expert Diagnostics 1000: a £1,000 limit for diagnostic treatment per person per policy year (excludes psychiatric cover). This option gives you approximately 30% discount when compared to Expert Diagnostics Comprehensive
- Or Expert Diagnostics 500: a £500 limit for diagnostic treatment per person per policy year (excludes psychiatric cover). This option gives you approximately 50% discount when compared to Expert Diagnostics Comprehensive.

Selecting one of these cover options will help you avoid unnecessary waiting times, with tests and consultations arranged quickly at a hospital convenient to you.

The following is available under the Expert Diagnostics cover options:

- consultations with a registered Consultant or Specialist
- investigations and tests, including blood tests, ultra sound scan and X-rays and related tests
- treatment room procedures such as excision of lesions, small biopsies and cryotherapy and any related pathology
- therapeutic injections for pain relief, dressings and wound care as part of Consultant supervised treatment
- dietitian advice – under supervision of your Consultant for treatment of a medical condition

Due to some excess options being the same as or exceeding the benefit limit some excess options are not available in conjunction with limited benefit cover options.

COVER OPTION	EXCESS OPTIONS NOT AVAILABLE
Expert Diagnostics 1000	**£1,000, £2,000**
Expert Diagnostics 500	**£500, £1,000, £2,000**

Please note, you can only select one Expert Diagnostic cover option per policy.

Therapy & Care option

therapies and care to assist recovery

We recognise the importance of being able to get prompt therapy to treat injuries and illness and to help relieve pain and restore you back to good health. This is why our Therapy & Care option offers cover for a range of manipulative, complementary and alternative therapies with a qualified Therapist.

You're also able to gain access to services which aid and support recovery after a spell in hospital.

Here's the full list of benefits:

- physiotherapy
- osteopathy
- chiropractic treatment
- sports therapy
- acupuncture
- homeopathy
- chiropody and podiatry – up to £400 per person per policy year
- speech therapy
- occupational therapy
- appliances/aids following an in-patient admission – up to £400 per person per policy year
- home help – up to £700 each admission

Please note, no excess or co-payment is applicable to this option.

Heart & Cancer option

extensive heart and cancer cover

Due to the potential complexity and duration of heart and cancer treatment it's not surprising that these can often be some of the most expensive conditions to treat. Our Heart & Cancer options give you peace of mind if you, or an insured dependant, need treatment for an acute heart or cancer condition.

Choose from 2 levels of cover for Heart & Cancer (for further details please refer to the schedule of benefits on page 22):

- Heart & Cancer Comprehensive,
- or Heart & Cancer Limited: a £50,000 limit for each Heart condition and an additional £50,000 for each Cancer condition per person for the lifetime of the policy. This option gives you approximately 25% discount when compared to Heart & Cancer Comprehensive.

Cover begins after a confirmed diagnosis.

Cover includes:

- surgical admission: heart (cardiac) surgery including implanted prosthesis, endoscopies and valves and related hospital charges
- non-surgical admission: heart (cardiac) medical care including related hospital charges
- heart (cardiac) necessary aftercare; including diagnostics, specialist scans and investigations, physiotherapy/rehabilitation and supportive care including care of a registered Dietitian within 1 year from the date of your admission or acute episodes of a previously covered condition to investigate and stabilise the symptoms in the short term
- cancer related surgery, including implanted prosthesis, endoscopies and hospital charges
- cancer treatment and medical admissions; including radiotherapy and chemotherapy, related treatment, care of secondary (metastatic spread) and palliative care
- necessary aftercare per cancer condition, including consultations, diagnostics, specialist scans and investigations and physiotherapy for up to 5 years following the initial diagnosis
- counselling for cancer, dietary advice and complementary therapy
- NHS cash allowance
- Nursing at home or convalescence benefit - up to a maximum of 14 days and £2,800 each admission immediately following a hospital admission either as an NHS or private patient under the specific direction of a Specialist/ Consultant (if you have chosen Heart & Cancer Limited this benefit will be deducted from the £50,000 overall benefit limit)

Please note, you can only select one Heart & Cancer cover option per policy.

Cash Benefits option

extra cash for everyday healthcare

With more options than ever to maintain a healthy lifestyle, the cost of looking after yourself can add up. With our Cash Benefits option you can help alleviate the occasional costs of everyday healthcare expenses with cash back to help pay towards treatment for dental, optical and health screenings.

For example you can receive cash reimbursement, up to agreed limits, for visits to the Dentist, Hygienist and Optician and towards a full health screening.

Simply choose the level of cover that suits you best:

CASH BENEFITS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Dental cover	£50 per benefit per person per policy year	£100 per benefit per person per policy year	£150 per benefit per person per policy year	£200 per benefit per person per policy year
Optical cover				
Health Screening				

Please note, no excess or co-payment is applicable to this option. Simply choose the level of cover which suits you best. The price is dependant on what level you choose and not your age. Also, if Cash Benefits is chosen by the main member, all child dependents up to the age of 25 years are FREE under this option.

Please note, in order to claim benefit for Dental and Optical treatment there is a qualifying period of 3 months continual Cash Benefits membership. During this qualifying period, no benefit is payable. In order to claim Health Screening benefit there is a qualifying period of 12 months continual Cash Benefits membership. During this qualifying period, no benefit is payable.

More ways to make your health insurance yourchoice

Once you have chosen your cover options, the next stage is to decide whether you would like to reduce your premiums, with an excess or co-payment, and then select your preferred hospital list.

Reducing your premiums

Adjust your premium to suit your budget by opting for a voluntary excess or choose one of our co-payment options.

By selecting an excess, and agreeing to pay a set figure towards the cost of your treatment per person each policy year, you'll receive a discount off your premium. The bigger the excess, the bigger the discount.

Alternatively, our co-payment options share the cost of treatment between you and ourselves, which also reduces your premiums. You pay 15% of each claim, per person per policy year, but only up to a maximum of either £1,000 or £3,000 per person per policy year depending on the option you choose.

More ways to make your health insurance yourchoice

Below is a table to illustrate the savings you can make on the Partnership hospital list by choosing an excess, or a co-payment option on your cover:

DISCOUNT OPTION	APPROXIMATE DISCOUNT
£100 Excess	9%
£300 Excess	25%
Co-Payment Option £1000	30%
£500 Excess	34%
Co-Payment Option £3000	39%
£1000 Excess	48%
£2000 Excess	58%

Please note these are approximate discounts only, and discount levels vary to those available on the Extended list

Due to some excess options being the same as or exceeding the benefit limit some excess options are not available in conjunction with limited benefit cover options.

Expert Diagnostics 500
The following excesses are not available with this cover option:
£500
£1,000
£2,000

Expert Diagnostics 1000
The following excesses are not available with this cover option:
£1,000
£2,000

NB. An excess or a co-payment is not applied to the Therapy & Care Option or Cash Benefits.

Hospital choice

One of the many benefits of your choice is knowing that you can choose where to receive private treatment from a wide range of hospitals throughout the UK. Either use our published Directory of Hospitals or search from our website to help find a hospital nearest to you.

You can choose from two hospital lists. The Partnership list includes many well known hospital groups like Spire Healthcare, Nuffield Health and BMI throughout the country, including some in London. Our Extended list offers a broader choice and includes some of the more expensive hospitals as well as all the hospitals from the Partnership list.

" The Service we have received has been excellent, providing us with peace of mind we value."

Mr D Kaye

Policy Overview

The your choice health plan is designed to meet the demands and needs of individuals who want quick access to private consultations, diagnostic tests, medical treatment, out-patient therapies and cash benefits.

This information is intended to help you select the most appropriate type of private health insurance for your own particular demands and needs – please read it carefully. The information provided by CS Healthcare in this document does not represent a personal recommendation as we can only supply information about our own products.

This brochure does not contain the full terms and conditions of the insurance contract. These will be provided in your Policy Document which will be sent to you when you join, or before on request. We also recommend that you read Health Insurance Explained published by the Association of British Insurers (ABI).

If you have any questions please call

0800 917 4325^

and our Membership Services Team will be glad to help you.

^ Calls to CS Healthcare will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

The purpose of private health insurance

Insurance policies provide cover against an unexpected event happening after the start of the policy. In health insurance this means cover for the cost of private health treatment for unforeseen medical conditions arising after your policy starts.

Your policy is not intended to cover conditions which you already have before your policy starts – these are called pre-existing conditions. Conditions which are related to pre-existing conditions are also not usually covered. A related condition is one that is caused by, or could be the cause of, another condition. Your policy will not cover all medical treatments. You should check your Policy Document and Registration Certificate carefully to see which treatments are covered and which are not.

This guide is a summary of the cover provided under **your choice**, but is a general guide only. If you have any questions please call **0800 917 4325^** and our Membership Services Team will be glad to help you.

What's covered under yourchoice?

The **your choice** health plan provides a range of cover options for medical treatment received in the United Kingdom, with a range of additional benefits. The compulsory level of cover is called Essential (for further information please refer to the schedule of benefits on page 19) which covers the cost of in-patient/day-patient treatment, including specialised scans, and necessary aftercare. Options then exist to extend cover to include the following:

- Out-patient consultations and tests with a Specialist under the Expert Diagnostic options (page 20)
- Benefits for physiotherapy and complementary therapies under Therapy & Care (page 21)
- Cover for heart and cancer treatment is available under the Heart & Cancer options (page 22)
- Finally, there are cash benefits available for dental, optical and health screenings under the Cash Benefits option (page 25)
- There is a choice of two hospital lists: Partnership or Extended.

^ Calls to CS Healthcare will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

Significant benefits

Essential
schedule of benefits

BENEFIT	COVER	NOTES
Hospital care for in-patient, day-patient treatment and out-patient surgery for pre-authorised treatment that takes place in any hospital from your chosen hospital list		
Specialised scans	Covered*	You are covered for Nuclear Scans including CT, MRI, PET, DAT, MIBG, Myelogram, Thallium and Perfusion/Ventilation scans.
Out-patient surgery and related charges	Covered*	Pre-authorised out-patient surgical procedures performed in an out-patient theatre, which are not performed as part of a Consultation in a consulting or treatment room.
Pre-operative tests to assess your fitness for surgery	Covered*	For up to 2 weeks prior to an authorised hospital admission to cover blood and urine tests, chest X-ray, ECG and assessment with an Anaesthetist if required.
Post-operative consultations, investigations, tests and physiotherapy	Covered*	As a part of necessary aftercare within 90 days immediately following a planned pre-authorised private hospital admission.
Surgical admissions related hospital charges including implanted surgical prosthesis	Covered*	Where you require surgery (including endoscopic procedures) cover will apply according to the average length of stay (for your surgical procedure) either as a day-patient or in-patient, including implanted prosthetics and all hospital surgical consumables.
Medical admissions and related services	Covered*	Where a stay as either a day-patient or in-patient is required for either diagnostic reasons or to treat and stabilise an acute condition by medical and by non-surgical means.
Specialist/Consultant fees	As per the CS Healthcare Fee Schedule	All Specialist/Consultant fees will be paid for medical, consultant, physician supervisions according to the rates of the CS Healthcare Fee Schedule. Please refer to the medical fees section of our website www.cshealthcare.co.uk or call our Claims Helpline on 020 8410 0440^ for full details.
Surgeon and Anaesthetist fees	As per the CS Healthcare Fee Schedule	All Surgeon and Anaesthetist fees will be paid according to the rates of the CS Healthcare Fee Schedule. Please refer to Surgeon and Anaesthetist Fees section within the Policy Document and the medical fees section of our website www.cshealthcare.co.uk for more information.
Private road ambulance	Up to £250 per person per policy year	Where required out of medical necessity after hospitalisation.
Convalescing and Nursing at Home	Up to a maximum of 14 days and £2,800 each admission	Immediately following a hospital admission either as a NHS or private patient under the specific direction of a Specialist/Consultant.
Parent accommodation	Covered*	For one or both insured parents staying with an insured child up to age of 16.
NHS cash allowance	£150 each night or day case admission to a UK NHS acute general hospital	Up to 28 nights inclusive of day case admissions (up to a maximum of £4,200) per person per policy year for eligible claims under this option.
ADDITIONAL FEATURES		
Your Care Package	Discretionary	A tailor-made, discretionary package of care agreed in advance of treatment, for those members electing to receive all, or part, of their treatment on the NHS. Your Care Package is considered for in-patient treatment only and does not cover out-patient treatment.
Out of band hospital benefit	Covered*	When using a hospital not included in our Directory of Hospitals, or included in your level of cover, we will consider reimbursement directly to you based on a customary and reasonable fee from a hospital on your list
Lifeline	24 hour availability 365 days a year	Health advice line with Doctor call back service.
Voluntary excess options	£100, £300, £500, £1000, £2000	Voluntary excess chosen will only apply to Essential cover, Expert Diagnostics and Heart & Cancer. Please refer to the 'Voluntary Excess and Co-payment options' section within the Policy Document for further details.
Co-payment option	15% of all claims up to either £1000 or £3000 per person per policy year	The co-payment option will only apply to Essential cover, Expert Diagnostics and Heart & Cancer. Please refer to the 'Voluntary Excess and Co-payment options' section within the Policy Document for further details.

***All costs must be necessary, customary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received, provided you use a hospital on your list.**

Expert Diagnostics option

schedule of benefits

BENEFIT	COVER			NOTES
Out-patient benefits				
	Expert Diagnostics Comprehensive	**Expert Diagnostics 1000**	**Expert Diagnostics 500**	
Consultations with a Specialist/ Consultant	COVERED*	COVER LIMITED TO £1,000*	COVER LIMITED TO £500*	On referral from your GP, Optician or Dentist or another Specialist/ Consultant. You are also covered if you wish to seek a second opinion or a referral to another Specialist/Consultant if necessary.
Investigations and tests: Including blood tests, ECG, EEG, ultrasound scan, X-rays and related tests				As part of Consultant supervised care or on GP referral.
Treatment room procedures such as excision of lesions, small biopsies and cryotherapy and any related pathology Therapeutic injections for pain relief or to treat specific symptoms Dressings and wound care Application or re-application of plaster of paris, casts, splints and braces				As part of consultant supervised treatment.
Dietitian Audiology Optometry				Under the supervision of your Specialist/Consultant for treatment of an eligible medical condition.
Psychiatric consultations and counselling	Up to £1000 per person per policy year and available only under Expert Diagnostics comprehensive.	No cover	No cover	On referral from your GP or another Specialist/Consultant to a Consultant Psychiatrist or recognised Counsellor.

*** All cost must be necessary, customary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received, provided you use a hospital on your list.**

Therapy & Care option

schedule of benefits

BENEFIT	COVER	NOTES
Manipulative out-patient benefits		
Physiotherapy Osteopathy Chiropractic treatment Sports therapy	Covered*	On either referral from your General Practitioner or under supervision from a Specialist/Consultant. We will initially pre-authorise 2 sessions in the first instance, if more treatment is required we will expect the Therapist to supply a treatment plan on request so we can confirm what further cover is available.
Complementary out-patient benefits		
Acupuncture Homeopathy	Covered*	On either referral from your General Practitioner or under supervision from a Specialist/Consultant. We will pre-authorise 2 sessions in the first instance, if more treatment is required we will expect the Therapist to supply a treatment plan on request so we can confirm what further cover is available. Excludes the cost of medicines and remedies.
Treatment and recovery benefits		
Chiropody and Podiatry	Up to £400 per person per policy year	To treat in-growing toenails, verrucas and for biomechanical assessment and orthotics.
Speech therapy	Covered*	Following a cerebrovascular accident, surgery or trauma to the vocal cords.
Occupational therapy	Covered*	Following an acute illness, or following an NHS in-patient admission to assess your needs or your activities of daily living or for a pre agreed course of therapy to aid recovery.
Appliances/aids following an in-patient admission	Up to £400 per person per policy year	For example, raised toilet seats, grab rails, walking sticks, zimmer type frames, bath stools and bath aids, chair raises or special chairs. Available when recommended by a Consultant or Therapist.
Home help	Up to £700 each admission	Immediately following a hospital admission, under the specific direction of the Specialist/Consultant and carried out by a registered home help or carer.

***All costs must be necessary, customary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received provided that the practitioner used is registered with the appropriate regulatory body as detailed on page 8 of the your choice Directory of Hospitals.**

Heart & Cancer option

schedule of benefits

HEART BENEFIT	COVER		NOTES
In-patient, day-patient and out-patient treatment			
	Heart & Cancer Comprehensive	**Heart & Cancer Limited**	
Surgical admission: Heart (cardiac) surgery including implanted prosthesis, including valves and related hospital charges	**COVERED***	**COVER LIMITED TO £50,000*** **(Per person per condition for the lifetime of the policy)**	This covers both open & closed surgical procedures. Covered for accommodation, theatre costs and all related investigations and medical costs including physiotherapy and dietitian. All Surgeon and Anaesthetist fees will be paid according to the rates of the CS Healthcare Fee Schedule. Please refer to the medical fees section of our website www.cshealthcare.co.uk or call our Claims Helpline on 020 8410 0440 for full details.
Non-surgical admission: Heart (cardiac) medical care including related hospital charges			Covered for accommodation, theatre and all related investigations & medical cost and Consultant fees. Where a stay is either a day-patient or overnight patient is required for either diagnostic reasons or to treat and stabilise an acute condition by medical and by non-surgical means.
Heart (cardiac) necessary aftercare; including diagnostics, specialist physiotherapy/ rehabilitation and supportive care including care of a registered Dietitian within 1 year from the date of admission for each acute condition treated. Or Acute episodes of a previously covered condition, to investigate and stabilise the symptoms in the short term.			Following a privately funded hospital admission or an acute recurrence of a condition pre-authorised by CS Healthcare, you are also covered for consultations & investigations including; CT, MRI, scans & investigations, PET, DAT, MIBG, Myelogram, Thallium and Perfusion/ Ventilation scans. Covered for procedures such as angiograms, transoesophageal echocardiograms, electrophysiological studies, cardioversion and pacemaker insertion and checks. If a new and separate heart condition requires admission as described above and this occurs during an already pre-authorised 12 month follow-up period, the period of necessary aftercare will be extended from the date of the new admission date accordingly.

CANCER BENEFIT	COVER		NOTES
In-patient, day-patient and out-patient treatment			
	Heart & Cancer Comprehensive	**Heart & Cancer Limited**	
Place of treatment: You are *covered* for: treatment in a hospital from your chosen hospital choice or a Home care provider from your chosen hospital choice.	COVERED*	COVER LIMITED TO £50,000* (Per person per condition for the lifetime of the policy)	■ Hospital – in-patient & day-patient ■ Hospital – out-patient ■ At home For all accommodation, theatre, related hospital costs and Consultant fees related to a surgical or medical admission to treat your condition and any related complications
Hospice Donation			Hospice Donation of £400 per person per policy year.
Diagnostic (after confirmed diagnosis of Cancer): You are *covered* for: Consultant Visits from a provider chosen from your hospital choice for all relevant blood tests, X-rays & Scans, Biopsy and aftercare			■ Consultant lead Care and Cancer Nurse Specialist Care. ■ Diagnostic test, to aid diagnosis, monitor your treatment and to follow you up to 5 years after diagnosis and according to your medical need. ■ Including Ultrasound, CT, MRI & PET, MIGB, Thallium, Perfusion & Ventilation scans. ■ Genetic & predictive disease profiling associated with eligible conditions
Surgery : You are *covered* for: Surgery from a provider chosen from your hospital choice and for Specialist/Consultant Fees involved in your care, including all related hospital, therapy and specialist nursing costs.			■ Removal of Primary & Secondary cancers. ■ Surgical Intervention for relief of symptoms and disease management, including palliative procedures. ■ The initial reconstructive surgery within 5 years of the first procedure or on completion of Radiotherapy and Chemotherapy treatment.
Preventative: You are *covered* for: Home care from a provider chosen from your hospital choice and for the delivery of symptom prevention, and associated investigations and consultant supervision Or Where home care is not available from a hospital chosen from your hospital choice.			■ Investigation as part of your disease management is covered. ■ Bone Strengthening drugs and therapies to manage disease progression are covered. Vaccines – are not covered and are available from your NHS GP.
Drug therapy: You are *covered* for: Home care or hospital from a provider chosen from your hospital choice and for the delivery of drug therapy to treat and control or maintain your disease and related symptoms.			■ Intravenous Chemotherapy & Biological therapies ■ Oral Chemotherapy & Biological therapies from a recognised provider. ■ Supportive drug therapy such as Steroids, anti sickness, antibiotics, pain relieving medications as an in-patient and 7 days take home drugs following an admission. ■ Drugs licensed to treat specific cancers, which have been assessed by NICE as safe and effective. ■ All accommodation, insertion of lines and related hospital costs and Consultant and specialist nursing fees.

Heart & Cancer option

schedule of benefits

CANCER BENEFIT	COVER		NOTES
In-patient, day-patient and out-patient treatment			
	Heart & Cancer Comprehensive	**Heart & Cancer Limited**	
Radiotherapy: You are *covered* for: Hospital from a provider chosen from your hospital choice and for the delivery of radiotherapy to treat and control or maintain your disease and related symptoms	**COVERED***	**COVER LIMITED TO £50,000*** **(Per person per condition for the lifetime of the policy)**	■ We cover external radiotherapy and internal radiotherapy, and brachytherapy. ■ Treatment of primary and secondary cancers. ■ Treatment for pain relief and to maintain remission. ■ To treat recognised complications
Palliative: You are *covered* for: Care to treat, relieve and control symptoms, including pain relieving treatment, either independently or alongside surgery, or radiotherapy.			■ Maintenance therapy including radiotherapy and drug therapy as described above. ■ Complementary Therapies to relieve symptoms.
End of life care You are *covered* for: Hospice Donation: Care and treatment in a hospital from your chosen hospital choice or a Home care provider from your chosen hospital choice, as a private patient when hospice care is unavailable. Nursing at Home, as a private patient when hospice care is unavailable.			■ Hospice Donation £400 per person per policy year. ■ For all accommodation, theatre, related hospital costs and Consultant fees related to a medical admission or home treatment to support your end of life care and any related complications. ■ For care at home provided by a registered care provider.
Monitoring: You are *covered* for: Supervision and monitoring of your treatment while receiving active care such as drug therapy or radiotherapy during primary or secondary care of your condition. Necessary aftercare per Cancer condition including consultations, for up to 5 years following the initial diagnosis of your condition.			■ You are covered for consultations and tests during a period of active care and for up to 5 years from the diagnosis of your condition and according to medical need including care of secondary conditions. ■ Including cover for Ultrasound, CT, MRI & PET, MIGB, Thallium, Perfusion & Ventilation scans. ■ If secondary disease occurs outside the 5 year monitoring period a maximum of 3 consultations will be covered following completion of drug therapy and radiotherapy or further surgical intervention. ■ Counselling, under the direction of your consultant. ■ Dietitian, under the direction of your consultant.

Other Benefits

If Heart & Cancer Limited is selected these benefits will be deducted from the £50,000 overall benefit limit

Convalescing and Nursing at Home	Up to a maximum of 14 days and £2,800 each admission immediately following a hospital admission either as an NHS or private patient under the specific direction of a Specialist/Consultant.
Private Road Ambulance	£250 per person per policy year where required out of medical necessity after hospitalisation
NHS Cash Allowance	For a surgical or medical admission; £150 each day/night after admission to a UK acute general NHS hospital for up to 28 days per person per policy year for eligible claims. OR For chemotherapy treatment; £60 per day case or overnight admission for the administration of intravenous chemotherapy at an UK acute general NHS hospital. OR For radiotherapy treatment; £30 per fraction of radiotherapy administered at an UK acute general NHS hospital
Your Care Package	A tailor-made, discretionary package of care agreed in advance of treatment, for those members electing to receive all, or part, of their treatment on the NHS. Your Care Package is considered for in-patient treatment only and does not cover out-patient treatment.

*** All cost must be necessary, customary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received, provided you use a hospital on your list.**

Cash Benefits option

schedule of benefits

CASH BENEFIT	COVER	NOTES
	Out-patient benefits	
Benefit amounts are per person, per policy year, per type of cover **Level 1:** Up to £50 **Level 2:** Up to £100 **Level 3:** Up to £150 **Level 4:** Up to £200	**Dental treatment** Check-ups, orthodontic, periodontal and hygienist treatment.	Benefit is not payable in respect of treatment under dental capitation schemes and dental insurance schemes. This benefit does not exclude any dental related condition that was in existence prior to the start of the policy i.e. pre-existing condition.
	Optical treatment Eye examinations, prescription glasses or sunglasses and prescription contact lenses.	No benefit is payable towards the cost of the following: ■ Repairs to glasses. ■ Eye laser surgery. ■ Frames without lenses. ■ Contact lenses used for cosmetic purposes. ■ Contact lens solution. ■ Non-prescription glasses or sunglasses. This benefit does not exclude any eye related condition that was in existence prior to the policy i.e. pre-existing condition.
	Health Screening Health Screening to assess the state of your general health to include: Screenings for Wellwoman & Wellman, Breast Cancer, Osteoporosis, Bowel Cancer, Cervical, Executive check-ups	■ Any claim for Health Screening must have been carried out by a recognised Health Screening Centre under the supervision of a registered Physician. ■ CS Healthcare will not pay any benefit towards health screenings other than the ones listed opposite. ■ CS Healthcare will not pay benefit for a Health Screening undertaken for the purpose of the member's employment, legal or insurance reasons. ■ CS Healthcare will not pay Health Screening benefit for any child dependant under the age of 25 years. ■ CS Healthcare will not pay benefit for missed appointment fees.

In order to claim benefit for Dental and Optical treatment there is a qualifying period of 3 months continual Cash Benefits membership. During this qualifying period, no benefit is payable. In order to claim Health Screening benefit there is a qualifying period of 12 months continual Cash Benefits membership. During this qualifying period, no benefit is payable.

Other benefits and features of yourchoice

Premium waiver

On the death of a member we will pay the premiums, until the next renewal date, for any dependant on the policy. For full details of the premium waiver benefit please refer to the 'Death of policyholder' section in the Policy Document.

" Always helpful, courteous, efficient. Glad to be able to support a non-shareholder friendly society and hope you can continue to survive as such."

Mrs V Harrington

Important general & specific exclusions

As with most health insurers, CS Healthcare does not cover you for pre-existing medical conditions or chronic conditions which are unlikely to be cured by treatment. Nor does the policy usually cover conditions which are related to pre-existing conditions. A related condition is one which is caused by, or could be the cause of, another condition.

A chronic medical condition is a disease, illness or injury which has one or more of the following characteristics:

- it needs on-going or long-term monitoring through consultations, examinations, check-ups, and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

However, we will provide cover for the initial diagnosis of a chronic condition, an acute episode of a chronic condition and for surgical intervention and necessary aftercare. A more detailed explanation of how we approach treatment for chronic conditions and acute episodes can be found in the 'Long-term treatment/Chronic Conditions' section of the Policy Document.

There are some general exclusions which will apply to your policy. You will find full details of these exclusions in the 'General Policy Exclusions' section of the Policy Document.

In addition there are some specific treatment exclusions which will apply to particular options. You will find full details of these exclusions in the 'Specific Treatment Exclusions and Advice' section of the Policy Document.

The main exclusions are:

- emergency treatment is not covered. In an emergency you should call an ambulance and/or visit an NHS accident & emergency department
- treatment outside the UK
- organ transplants
- routine monitoring of any medical condition
- for Cash Benefits policy holders, health screening benefit will not be paid to any child dependants held on the policy
- surgical correction of short or long-sightedness
- hearing aids and other external prostheses
- National Health Service accident and emergency treatment (including unplanned NHS Intensive Care)
- treatment for infertility
- treatment for drug abuse, alcoholism or self-inflicted injury
- cosmetic surgery
- HIV and AIDS
- routine pregnancy or childbirth
- professional sports
- in-patient psychiatric treatment

How we assess your health

Underwriting is the process by which an insurer decides on what terms it will accept a person for cover based on the information they supply. This section is designed to explain the underwriting methods by which you can apply for cover, so that you can decide the one that best suits your requirements.

Full Medical Underwriting

If you choose this option, you will be asked a number of questions about your health. These will enable us to understand your medical history (and that of any dependant whom you wish to insure). It is important that you consider the questions carefully, for each person to be covered, and answer them fully. We will review your details and inform you of the terms of insurance we are prepared to offer. If necessary, we may need to ask your doctor for further information to help us to do this. If this is the case you will be liable for any costs associated with obtaining this.

If you have a pre-existing condition that may need treatment in the future, we will usually exclude it from the cover along with any conditions related to it. We will show any personal exclusion on the Registration Certificate you receive from us when we have processed your application. The same process will also apply for any dependants included in your application.

Review of personal exclusions

You may ask us to review a personal exclusion; this is usually after two full years of membership or sooner if indicated on your Registration Certificate. There are some circumstances where we may be able to amend your underwriting terms for certain conditions. For us to consider removal of a personal exclusion we will require a medical report from your General Practitioner (GP), or medical practitioner confirming that the condition was cured, by which we mean that you have no active signs and symptoms, and you are not requiring regular medication or medical supervision. If you wish us to consider the removal of a condition, you should contact us before obtaining a report from your GP. If your GP makes a charge for issuing a medical report, this cost must be met by you.

It is important to understand that some medical conditions may never be reviewed. Of course, any new medical conditions arising after the start of your policy will be covered immediately subject to the policy terms and conditions.

What is the advantage of Full Medical Underwriting?

Although this option involves more of your time when completing your application, it does mean that, when you receive your policy documentation, you will know which conditions are excluded from cover. If you need to make a claim we will usually be able to authorise any required treatment over the telephone. See page 34 for more details on how to claim.

Note: You must ensure that you provide full and accurate information in answer to the health questionnaire. Failure to do so may mean that we cannot cover a claim or even that your policy is cancelled. If you are unsure whether we would want to know about a particular condition, you should tell us about it.

Moratorium Underwriting

If you choose this option you do not need to fill in a health questionnaire. Instead we will automatically exclude the cost of treating any pre-existing conditions for which you (or any dependant included in your application) have received treatment and or medication, asked advice on, or had symptoms of (whether diagnosed or otherwise), during the 5 years immediately before your private medical insurance commences.

If you do not have symptoms, treatment, medication or advice for those pre-existing conditions, and any directly related conditions, for two continuous years after your policy starts, then we will reinstate cover for those conditions.

You should understand that long term medical conditions, which are likely to continue to need regular or periodic treatment, medication or medical advice, will never be covered under your policy.

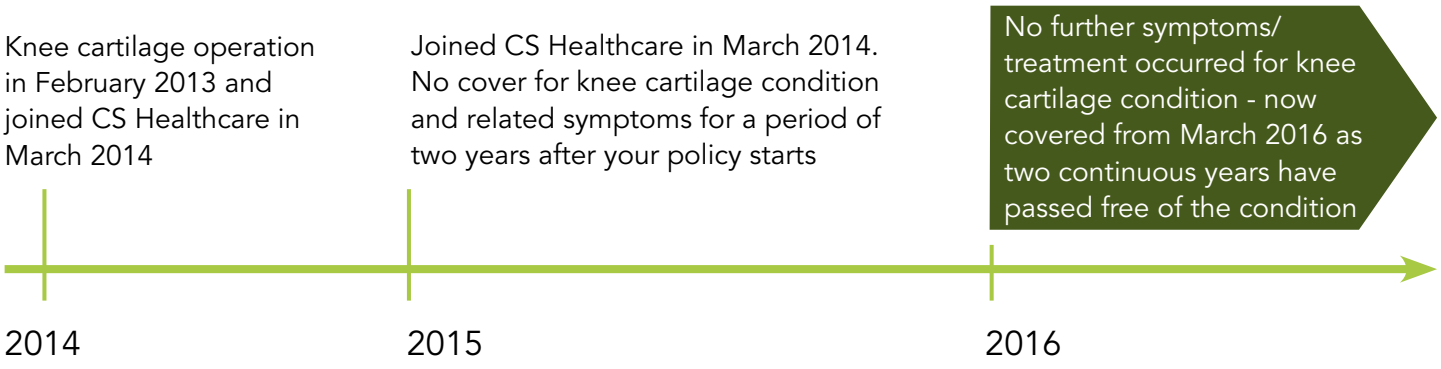
You should not delay seeking medical advice or treatment for a pre-existing condition simply to obtain cover under your policy.

At the point of every claim under a Moratorium policy, and before any treatment can be authorised, your General Practitioner (GP) will be required to submit a copy of the referral letter so that we can confirm if the condition is new or pre-existing. This procedure is continuous throughout the life of the policy. Your GP may charge you for this service, the cost of which must be met by you.

What is the advantage of Moratorium Underwriting?

If you choose this option you will only be asked to provide basic information about you and any dependants you wish to insure. You will not be asked to disclose details of your medical history, but it relies on you to understand that if you have any medical conditions these will be excluded from cover. Also, if you can satisfy the criteria outlined in the opposite section, for a pre-existing condition, then treatment for that condition will automatically be covered should it later recur, subject to the policy terms and conditions.

Moratorium example



Examples of how both options works

" What if I suspect I am suffering from a condition (for example, I have a lump) but have not seen a doctor about it, nor received any firm diagnosis before my cover starts. Will I be covered if I need to have any investigations or treatment for the condition once my policy has started?"

Moratorium Underwriting

Because you have a symptom of the condition before your cover starts, even though you are not sure exactly what it is, the costs of receiving any private treatment for the condition, and any related conditions, will not be covered by your policy.

Full Medical Underwriting

You would be expected to disclose the symptoms on your health questionnaire. Treatment for this condition, and any related conditions, would not be covered by your policy.

" Some time after my cover starts, I go to my doctor for a routine visit. A heart condition is diagnosed which must have started to develop before my policy started. What is the position?"

Moratorium Underwriting

The Moratorium clause only applies to any medical condition, or related condition (or both), which you were aware of in the five years before your policy started, so if:-

- the heart condition was first diagnosed after your policy started, and
- you had no previous treatment for any related conditions, such as high blood pressure or chest pains and
- you had no symptoms before your policy started

Cover would be available even if it was proved that the condition must have existed before your policy started.

Full Medical Underwriting

The position would be the same under Full Medical Underwriting as under Moratorium.

" I had an operation on my right knee recently. Will I be covered for any further treatment to it after my policy starts?"

Moratorium Underwriting

Providing you do not have any symptoms, need treatment, advice or medication for your condition for two continuous years after your policy starts, then should that condition recur after this period you would be covered for any further treatment to cure it (subject to the policy terms and conditions).

Full Medical Underwriting

Treatment for this condition would be excluded from cover. However, we would be willing to review this position in the future (the timing of the review would depend on how recent the operation had been).

" How do regular check-ups affect the Moratorium?"

It depends what the check-ups are for. For example:

i) If you have a specific condition before your policy starts and your doctor, or specialist, recommend that you continue to have check-ups for that condition, then we will not cover the cost of private treatment received for that condition. Cover will only apply once you have been discharged from care and have no further treatment, medication or advice for a continuous period of two years.

ii) In the same situation described above, if you choose to continue having check-ups for your own peace of mind even though you have been discharged from care, we will cover you for that condition if you satisfy the terms of the Moratorium (in other words, you do not need any medication, treatment or advice for two continuous years).

iii) If you have general health check-ups simply in the interests of maintaining good health, and not for any particular condition, we ignore them when applying the Moratorium.

Note: We do not pay for check-ups in any of the circumstances described above.

Significant features and other important information

Switching your health insurance to CS Healthcare

The intention of our switch terms is to allow those with current or recent private medical insurance to join CS Healthcare, in most cases, with the same method of underwriting as their previous insurer.

If you wish to apply for switch terms you will be asked a number of questions about your health. These will enable us to understand certain information about your medical history (and that of any dependant whom you wish to insure).

It is important to understand that there are certain types of treatment and pre-existing medical conditions which may mean that you do not qualify for or under CS Healthcare's switch terms.

These conditions are outlined within the switch underwriting section of the **your choice** proposal form, and include (but are not limited to) conditions such as stroke, cancer and joint replacements.

It is important that you consider the questions carefully, for each person to be covered, and answer them fully. Our underwriters will review the content of the completed switch proposal form and advise you whether you are eligible for CS Healthcare's switch underwriting terms. If necessary, we may need to ask your doctor for further information to help us to do this, if this is the case you will be liable for any costs associated with obtaining this.

In order to qualify for switch terms you and any dependant included on the policy must also:

- Currently be insured under a UK private medical insurance policy, or have had a policy of this kind which expired within 60 days of your requested start date with CS Healthcare.
- Be a maximum age of 74 years and 11 months at the proposed start date of the policy.
- Provide a copy of the most recent certificates of insurance for each dependant applying for switch terms

Please Note: we will be unable to validate cover or authorise any claims for benefit until we have received and reviewed your previous certificate of insurance. Additionally, if valid certificates are not received within 60 days of commencing your policy, cover will be terminated by CS Healthcare.

A premium loading will be applied to any accepted 'switch' policy to reflect the additional risk to the Society.

It is possible for a switch policy to include dependants who are not eligible for switch terms, providing that the main applicant qualifies for switch. Those dependents that are not eligible for switch will need to complete the relevant

section of the **your choice** proposal form to select their chosen underwriting type. CS Healthcare will then advise the main applicant of the terms of insurance it is prepared to offer for all individuals included within the proposal form.

If you do not qualify for our switch underwriting terms you will be able to apply for either Full Medical Underwriting or Moratorium underwriting terms.

How we calculate your premium

The prices of our plans are reviewed at the annual renewal date. Premiums are calculated and charged according to individual ages for Essential, Expert Diagnostics and the Heart & Cancer options reflecting people being more likely to claim as they get older. However, the final age-related premium increase will occur at the renewal following your 80th birthday. Premiums for children are separated into two age bands, 1 to 11 years and 12 to 17 years. However, children under 1 year old and the eldest child under 18 years of age are covered for free. Premiums for Therapy & Care and Cash Benefits are at a flat rate and not affected by age. If Cash Benefits is selected by the member, all child dependants on the policy up to the age of 25 years are covered free for this option. It is important to remember the premium at annual renewal will also reflect the overall cost of benefit expenditure and medical inflation e.g. availability of new treatments and improvements in medical technology.

How long am I covered for?

Your membership will start on the policy inception date following receipt and acceptance of your completed Proposal Form. Provided you continue to pay the premiums, and adhere to your Member Responsibilities (please refer to the 'Member Responsibilities' section of the Policy Document for further details), your cover can continue until you cancel your policy. Premiums are payable monthly or annually. Each monthly premium buys cover for the calendar month in which it is paid. Each annual premium buys cover for the following 12 calendar months after it is paid. If any premium is not paid on the date it is due, cover will stop on that date if the premium is not received within 60 days. No benefit will be payable during this period for which premiums have not been paid, unless a period of free cover applies. Your policy is renewable on an annual basis at which time you have the opportunity to change your level of cover. We will write to you within a reasonable time-frame before your renewal date to notify you of any changes that will apply.

Your cancellation rights

You can cancel your membership within 15 days of receiving your policy documentation, or 15 days from the commencement or policy renewal, and receive a full refund, provided you notify us in writing or by telephone and no claims have been made. Members may cancel their policy at any other time by notifying us in writing or by telephone. It is the responsibility of the member to ensure the Society has received this notification. Monthly premium payments will cease from the next instalment date, provided at least 15 days notice has been given. If premiums are paid annually, they will be refunded on a pro-rata basis for whole months only (if applicable), less any pre-payment or introductory discount.

How do I make a claim?

If you need to make a claim you can telephone our Claims Helpline on 020 8410 0440^ Monday to Friday 8am - 6pm for assistance, write to us or email us. It is important that you contact us before visiting a specialist or arranging treatment to check you have adequate cover on your policy.

Please be aware, if you make a claim for symptoms that initially occur within the first year of membership, we will ask you to provide a copy of the GP referral letter for assessment of your claim.

All authorised bills will be settled directly with the Specialist or hospital or, if for any reason the member has paid the bills, directly with the member. Please refer to the 'How to claim for Health Insurance' and 'Claim terms and conditions' section of the Policy Document for details.

What to do if you have a complaint

The Society makes every effort to ensure that members are satisfied with the level of service we provide. However, if things do go wrong we have an open and fair complaint procedure. In the event that you are unhappy with our service, please contact us to explain the reason for your dissatisfaction.

Write to:
Civil Service Healthcare Society Limited
Princess House, Horace Road
Kingston upon Thames
Surrey KT1 2SL.

Telephone:
Membership Services Team on 020 8410 0400^

We will investigate your complaint and provide you with a written response. If you are unhappy with the outcome of our investigation you may refer the matter to the Financial Ombudsman Service.

Their contact details are:

Financial Ombudsman Service
Exchange Tower
London
E14 9SR

Telephone: 0300 123 9 123
E-mail: complaint.info@financial-ombudsman.org.uk

^ Calls to CS Healthcare will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

Are we covered by the Financial Services Compensation Scheme (FSCS)?

We are covered by the Financial Services Compensation Scheme, and you may be entitled to compensation from the scheme if we are unable to meet our obligations to you. The maximum level of compensation for valid claims within the Terms and Conditions of your policy is 90% of the claim, with no upper limit. Further information about compensation arrangements are available from:

The Financial Services Compensation Scheme
10th Floor,
Beaufort House
15 St Botolph Street,
London,
EC3A 7QU

Telephone: 0800 6781100 or 020 7741 4100

Who regulates us?

Civil Service Healthcare Society Limited, Princess House, Horace Road, Kingston upon Thames, Surrey, KT1 2SL is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Our Financial Register number is 205346.

Our permitted business is to provide private medical insurance contracts.

You can check this on the Financial Services Register by visiting the Financial Conduct Authority's (FCA's) website at www.fca.org.uk/register or by contacting the FCA on 0800 111 6768.

If you have any queries, please contact us on

0800 917 4325^

www.cshealthcare.co.uk

Find us on Facebook Just search cs_healthcare

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