2018

Changes to your Essential Health plan from renewal

Individuals & Families

We're here to help

Call us on +44 1276 486455
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What's different for 2018

There will be quite a few changes to your plan from your renewal date. We have highlighted the key changes in the first part of this booklet.

Changes to your benefits

The second part of this booklet outlines the improvements and changes we have made to your benefits from your renewal date.

Your renewal premium

The third part of this booklet explains your renewal premium, and sets out various options should you wish to explore ways to reduce it. Please contact us if you would like to discuss your renewal premium. We'd love to hear from you.

Changes to your terms & conditions

The fourth and final part of this booklet outlines some changes we have made to the terms & conditions governing your plan. They are small changes, but it is important that you are aware of them before you renew.

What's different for 2018

We are always thinking about how we can improve our health plans and the service that we offer to our customers. We have made quite a few changes this year, and these will affect you from your plan renewal date. These changes are outlined for you in this booklet: please read it in conjunction with your 2018 plan agreement. The most important changes are highlighted for you on this page.

Your custom is very important to us, and we are here if you would like to discuss any of the changes we have made to your plan, or if you would like to talk about your premium increase. You can find our contact details throughout this booklet.

1.1 Higher benefit limits

We have made some improvements to your benefits. For example, we have increased your benefit limit for genome testing of cancers.

The changes are stated in full in the next part of this booklet. Please also refer to your 2018 plan agreement.

1.2 Explaining your renewal premium

An important part of our plan changes is pricing. With the introduction of expensive new treatments and drug therapies, medical treatment costs around the world are on the rise. It is inevitable that insurance premiums will have to keep pace. Because of this, your premium for 2018 is higher than your premium for 2017. We believe that our plans represent good value, but we would encourage you to shop around and see for yourself. For more information on our pricing policy, please visit our special online resource.

Please don't hesitate to contact us about your renewal premium. We'd love to hear from you. You can also find ways to reduce your premium in this booklet.

1.3 The insurer for your plan

Your health plan is underwritten by the Allianz group of companies, one of the largest financial services providers in the world. Previously, the company that insured your plan was Allianz Benelux N.V., registered in the Netherlands. From your plan renewal date, the company that insures your plan will be AWP Health & Life S.A., registered in Paris, France. Both companies are part of the Allianz group, and the change of insurer will not affect the service you receive from us.

Changes to your benefits

This part outlines in full the changes to your benefits from your plan renewal date. Please read in conjunction with your 2018 plan agreement.

2.1 Terminal illnesses

We have revamped the terminal illnesses benefit to make it clearer and easier to understand. The terminal illnesses benefit was previously set out as follows:

Terminal illnesses

Essential Care	Essential Care Plus
Lifetime limit of US$25,000	Lifetime limit of US$50,000

Palliative and/or hospice care, and care for persistent vegetative state

On diagnosis of a terminal medical condition covered by your plan, all costs for treatment received on the advice of a medical practitioner or specialist for the purpose of offering relief of symptoms. This includes all hospital or hospice accommodation, and nursing care by a qualified nurse. All treatment and care received after you have been in a persistent vegetative state for a period of eight consecutive weeks due to an injury or illness covered by your plan.

Cover is up to the lifetime limit for your plan.

From your renewal, we have renamed this benefit as the **lifetime care benefit**. We have also re-written some of the benefits within this section. This section now reads as follows:

Lifetime care

Essential Care	Essential Care Plus
Lifetime limit of US$25,000	Lifetime limit of US$50,000

Hospice and palliative care

On diagnosis of a terminal medical condition covered by your plan, all costs for treatment received on the advice of a medical practitioner or specialist for the purpose of offering relief of symptoms. This includes all hospital or hospice accommodation, and nursing care by a qualified nurse.

Cover is up to the lifetime limit for your plan.

Artificial life maintenance

Treatment you require after you have already been on artificial life maintenance for 8 weeks.

Cover is up to the lifetime limit for your plan.

Persistent vegetative state and neurological damage

Treatment you require after you have been in hospital for 8 weeks for permanent neurological damage or if you are in a persistent vegetative state.

Cover is up to the lifetime limit for your plan.

Your new lifetime care benefit looks very different, but, in practice, all we have done is group together in one place various terms & conditions that already featured in different places in your plan agreement.

2.2 Cancer genome testing

We have increased the benefit limit for cancer genome testing to US$6,000. Previously, the limit was US$2,000.

This change is based on research we have undertaken into genome testing technology around the world.

2.3 Reconstructive surgery

We have amended the wording for your reconstructive surgery benefit. You are now eligible for only two reconstructive surgeries per lifetime.

2.4 Out-patient physiotherapy

We have amended the wording for your out-patient physiotherapy benefit. We now require a medical report after your 6th session of physiotherapy. Previously, it was after your 10th session. After you have had 6 sessions, we will write to your doctor for a medical report if you need more physiotherapy treatment.

2.5 Moratorium underwriting

This change only applies if your plan is underwritten on a moratorium basis.

We have made some changes to plans that are underwritten on a moratorium basis. Previously, we treated moratorium plans with what are known as 'all:2' terms.

'All:2' means that medical conditions existing before the start date of your plan are not covered. However, after two years of continuous cover from the start date of your plan, pre-existing medical conditions may be eligible for benefit, subject to the terms & conditions of the plan.

From your renewal date, we will treat moratorium plans with what are known as '5:2' terms.

'5:2' means that only medical conditions existing for the 5 years before the start date of your plan are not covered. However, after two years of continuous cover from the start date of your plan, pre-existing conditions may be eligible for benefit, subject to the terms and conditions of the plan.

This change comes at no additional cost.

Your renewal premium

3.1 Premium increases

The premium increase for most of our customers will be 5%. However, it may be higher for one (or more) of the reasons stated below.

3.2 If you have entered a higher age bracket

We calculate your premium according to the age bracket you fall into. Each age bracket spans at least five years (e.g. 25-29, 30-34, 35-39). If your premium increased more than you were expecting, it may be because you now fall into a higher age bracket. The good news is that you will remain in this age bracket for five years, so future premium increases will be comparatively less.

3.3 If you have a US$1,600 claim excess

We have reduced the premium discount for this excess.

3.4 If you have a child-only plan

We are changing how we offer child-only plans because of the high number of claim we receive. From your renewal date, you will need to pay a higher premium for each child. In addition, the minimum excess we can offer on child-only plans is now US$50 per claim. If you previously had a plan with a nil excess, you will notice that renewal has been offered on the basis of a US$50 per claim excess.

3.5 Ways to reduce your premium

If you are concerned at your premium increase, there are ways you can reduce your premium.

Consider a different plan

You may be able to switch to a cheaper Essential plan with fewer benefits. Please visit our website to view our 2018 plan range.

Change your payment frequency

If you are currently paying your premium on a monthly basis, you can save 5% by paying on an annual basis. You can also make a saving if you are currently paying your premium on a quarterly or semi-annual basis.

Increase your excess

Increasing your excess can reduce your premium. We have several excess options, ranging from US$50 per claim, all the way up to US$10,000 per annum.

Please don't hesitate to contact us about your renewal premium. We are here to help.

If you previously had a child-only plan with a nil excess, you will notice that renewal has been offered on the basis of a US$50 per claim excess.

If you want to know more about the ways you can reduce your premium, please contact us. We'd love to hear from you.

Contact us about switching to a different excess.

Changes to your terms & conditions

4.1 Administrative changes

The following changes affect when you must contact us about your treatment, and how much time you have to submit your claims.

When you are admitted to hospital in an emergency

If you are admitted to hospital in an emergency and it is not reasonably possible for you to contact us in advance of your admission, we will consider your claim provided you contact us within 24 hours of your admission. If you do not contact us within 24 hours, we may decline your claim, or subject your claim to 20% co-insurance.

The time limit for submitting reimbursement claims

You must submit your claim within 6 months of your treatment date, unless it was not reasonably possible for you to submit the claim within this time. We will not pay any invoices received by us more than 12 months after the treatment date.

4.2 Artificial life maintenance

We have added the following exclusion regarding artificial life maintenance:

You are not covered for artificial life maintenance, other than any benefit you are eligible for under the lifetime care benefit.

4.3 Change to the definition of 'medically necessary treatment'

Previously, we defined medically necessary treatment as follows:

Medically necessary treatment

Treatment that is medically appropriate and necessary to treat a condition and which is consistent with UK medical practice and guidelines regarding its type, frequency and duration. The UK guidelines used for the purpose will be those published by the National Institute for Health and Clinical Excellence (NICE) in the UK.

We realise that different countries follow different protocols regarding what is medically necessary. As such, we have amended our definition as follows:

Medically necessary treatment

Treatment that is medically appropriate and necessary to treat a condition covered by your plan. The treatment must be:

- *essential to diagnose or treat a patient's condition, illness or injury*
- *consistent with the patients, symptoms, diagnosis or treatment of the underlying condition*
- *in accordance with generally accepted medical practice and professional standards of medical care at the time*
- *required for reasons other than the comfort or convenience of the patient or his/her physician*
- *proven and been demonstrated to have medical value, with international medical and scientific evidence of the effectiveness and safety of the treatment*

- *considered to be the most appropriate type and level of treatment taking patient safety and cost effectiveness into consideration*
- *provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of the patient's medical condition*
- *provided only for an appropriate duration of time.*

4.4 Change to the definition of 'pre-existing medical condition'

We have added 'joint replacements' to the list of conditions that are excluded if you have had a joint replacement at any time before your date of entry.

4.5 Change to the exclusion for experimental drugs and treatment

Previously, the experimental drugs and treatment exclusion was as follows:

Experimental drugs and treatment

Treatment which is experimental, or has not been proven to be effective. This includes, but is not limited to:

- *treatment that is provided as part of a clinical trial*
- *treatment that has not been approved by the National Institute for Clinical Excellence (NICE)*
- *any drug or medicine that is prescribed for a purpose for which it has not been licensed for or approved by NICE*
- *any combination of drugs or medicines prescribed for the purpose for which they have not been licensed for, or approved by NICE*

In order to reflect different medical protocols in different countries, we have amended this exclusion as follows:

Experimental drugs and treatment

Treatment or medicine which in our reasonable opinion is experimental or unproven based on generally acceptable current clinical evidence and generally accepted medical practice.

4.6 Change to the exclusion for vitamins, dietary supplements, and natural substances

Previously, this exclusion read as follows:

Vitamins, dietary supplements, and natural substances

Naturally available substances that can be purchased without prescription, including, but not limited to, vitamins, minerals and organic substances. Please note however these may be covered under the 'Routine maternity care and childbirth' benefit.

From your renewal, the exclusion reads as follows:

Vitamins, dietary supplements, natural substances, and creams

You are not covered for commercially available substances that can be purchased without prescription, including, but not limited to, vitamins, minerals, organic, substances, moisturisers, oils, creams, or other pharmaceutical products, other than any treatment available to you under the routine maternity care and childbirth benefit within the maternity costs benefits section of the table of benefits.

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