Association of British Insurers

ABI Health

Are you buying private medical insurance?

Take a look at this guide before you decide

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Contents

About this guide

This guide is for individuals who are thinking about buying private medical insurance (PMI) for themselves and their families.

We have designed this guide to help you understand more about what PMI in the UK is, why people buy it, and how it works, so that you will be able to make an informed choice before you buy a policy.

As well as this guide, the information you receive from insurers offering PMI will tell you more about the products that you are considering buying. They outline what is, and is not, covered. Remember that different products from different companies will vary. If you have any questions, your insurance company will be able to answer them and you can also consult an independent financial adviser.

If you get PMI as a benefit through your employer, your employer will have all the information about your insurance cover which may be different from the general information detailed in this guide for individuals purchasing PMI. For example, the cooling-off period will not apply if your employer has purchased the insurance for you.

Understanding what you are buying

Buying private medical insurance is similar to buying any other type of insurance policy.

Private medical insurance is available in a range of cover levels and premium levels designed to meet the needs of different customers. For example, your choices may include: types of treatment, levels of cover for those treatments, how you access care, where treatment is provided, and your contribution towards the treatment cost (the excess). Take the time to understand the cover available to help you make an informed choice.

You should:

- compare the benefits of each insurer
- compare any cover limits or monetary amounts
- consider your own health needs
- consider what benefits are available to help keep you in good health
- ask questions about how the cover works

If your employer has purchased the cover on your behalf, they will have made these decisions for you. Your employer will have all the information about your insurance cover.

If you are buying a PMI policy for yourself (and your family), make sure that you understand what you are covered for and the limits that will apply if you make a claim; read the policy terms and conditions. You should contact the insurer who will be happy to talk you through the cover available to you. You can also consult an independent financial adviser.

For example, you might want to know:

- Are there monetary limits on the policy - how much towards the cost of a treatment, or course of treatments, do you want covered?
- How does an excess work – will it be applied per claim or per policy year?
- What cover is there for cancer - what treatments are covered and for which stages of the disease?
- Is there a no claims discount – what will happen to my future premiums if I make a claim?

There can be limits on cover for drug treatments. You might want to ask about these. A drug treatment that your insurer has covered might not be available on the NHS when your PMI cover ends. Your insurer will contact you as you approach the end of cover about the options available to you so you can discuss it with your specialist. These could be:

- Return to the NHS and receive the treatment there, if available
- Return to the NHS and receive alternative treatment
- Pay for the treatment privately on a self-pay basis

What is private medical insurance?

Private medical insurance is designed to cover the cost of private medical investigations and treatment for 'acute conditions' that start after your policy begins.

An acute condition is a disease, illness or injury that is likely to respond quickly to treatment that aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery. Your insurer can tell you about their cover for this and whether or not they will provide any cover for longer-term conditions (typically referred to as 'chronic conditions').

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

- it needs long-term monitoring, control or relief of symptoms
- it requires rehabilitation
- it continues indefinitely
- it has no known cure or is likely to come back

Some policies may cover certain types of, or elements of, long-term treatment or treatment for chronic conditions, but this is not usually the main purpose of PMI.

PMI is designed to work alongside, not to replace, all the services offered by the NHS and customers can continue to use the NHS.

WHY BUY PRIVATE MEDICAL INSURANCE?

People buy this type of insurance to have:

Timely access to healthcare

- Prompt referral to a consultant
- Quick admission to hospital
- Treatment at a convenient time and place

Choice of healthcare

- Direct care by a consultant
- Advanced treatment options, such as access to some cancer drugs that are not available on the NHS

High-quality private clinic and hospital accommodation

- Privacy of an en-suite room
- Home amenities, such as TV
- Comfort and cleanliness

HOW DOES PRIVATE MEDICAL INSURANCE WORK?

Although policies can be different, medical treatment usually has to start with a referral by your GP for specialist treatment. Before you arrange any private treatment, you should call your insurance company to check that you are covered for the treatment and to discuss your options for accessing care.

Stay in touch with your insurer at each stage of your treatment. Your insurer will confirm your cover. It is likely that treatments for some illnesses, including pre-existing conditions (conditions from which you are already suffering, or have already had before your policy started) will not be covered by a private medical insurance policy (see section 4 of this guide).

How do I buy private medical insurance?

Private medical insurance is provided only by insurers and may be bought:

- direct from the insurer
- through an independent adviser
- through an agent (bank, building society or retail outlet, such as a supermarket)

You can apply for insurance:

- over the phone
- face-to-face
- online
- by post

The method of application may vary by insurer. If you are using the internet, try searching for key words such as 'health insurance' as well as 'medical insurance'.

An insurer, or a tied agent who sells policies on an insurer's behalf, is only able to discuss that insurer's own policies. An independent adviser offers policies from a range of insurers.

Independent advisers give you recommendations after assessing your needs. They are responsible to you for the advice they give. If you buy direct from an insurer or an insurer's agent, they will also assess your needs, but they can only give you advice on which of their own policies best suits you.

Your adviser must explain whether they are:

- independent
- advising on a range of insurers
- a representative of one insurer

If you buy direct from an insurer or insurer's agent without receiving advice, it is your responsibility to choose a policy that is right for you.

You will be asked to fill in an application, and may be asked for information about your health. Your application, or any declaration you make to your insurer, is very important. In fact, it forms the basis of your contract with your insurer. You must answer any questions you are asked as fully and as accurately as you can, to the best of your knowledge and belief. If you do not, your insurer may reduce your claim or refuse to pay and cancel your policy. If you are unsure whether something is important, it is best to tell your insurer.

Once your application has been accepted you will be told when cover will start.

CANCELLATION PERIOD

Your insurer will send you policy documents when your policy has been set up. You have at least 14 days from the day you receive them to decide whether the product is suitable for you. This is commonly known as a 'cooling-off period'. If you want to cancel your policy, you must do so within the stated period and tell the insurer that you want to cancel your cover. If you have made any payments you will usually receive a full refund unless you have made a claim.

Will I need to give details about my health?

You will not normally be covered for any illnesses you are currently suffering from, or have already had. These are known as 'pre-existing conditions'. You must answer all questions as fully and as accurately as you can, to the best of your knowledge and belief.

There are two main methods that PMI companies use to deal with your application for cover. These are:

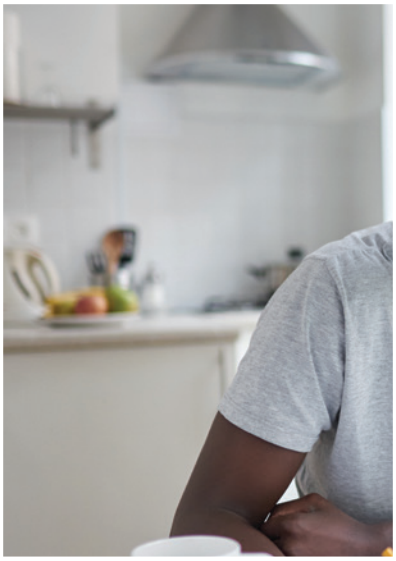
- full medical underwriting
- moratorium underwriting

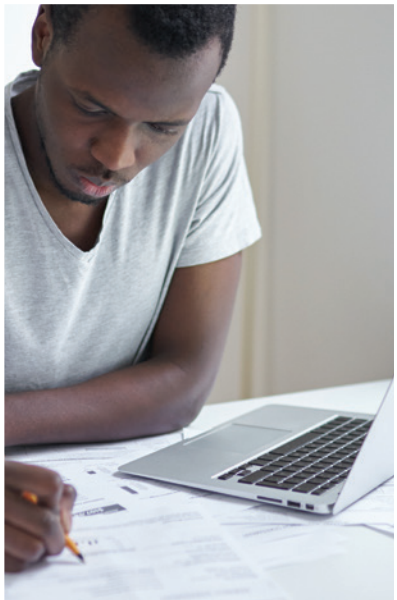
All PMI companies will offer you the full medical underwriting option. Only some companies offer the moratorium option.

FULL MEDICAL UNDERWRITING (MEDICAL HISTORY DECLARATION)

You are asked to give details of your medical history. The insurer may write to your doctor for more information, but they do not do so in every case. You must give all the information you are asked for. If you do not, your insurer may reduce your claim or refuse to pay and cancel your policy. In some cases, insurers may also decline offering any cover.

If you are not sure whether to mention something, it is best to do so. If you have a medical condition that is likely to come back, the insurer will issue a policy, but that condition (and any related to it) might not be covered. Depending on a number of factors, the condition may never be covered, or not covered for a set period of time.





MORATORIUM UNDERWRITING

You are not asked to give details of your medical history. Instead, the insurer does not cover treatment for any pre-existing medical condition that you have received treatment for, diagnostic tests for, taken medication for, asked advice on or had symptoms of, in the years immediately before your policy started. In other words, you will not be covered for any condition that existed in the past few years. This time period can vary across different insurers.

These conditions may automatically become eligible for cover. But this will only happen when you do not have symptoms of, or receive treatment, medication, tests and advice (from your GP, a healthcare professional or a specialist) for that condition, or a related condition, usually for a continuous period of two years after your policy has started. This time period can vary across different insurers.

You do not need to tell the insurer about your medical history when you take out the policy. If you claim, however, your insurer might ask for medical notes that are needed to decide if your claim can be covered.

There are some conditions, for example chronic conditions, that will probably never be covered. This is because you will always need treatment, medication, tests or advice for them. You should not delay getting medical advice or treatment, simply to get cover under the moratorium terms.

If you have general health check-ups simply in the interests of maintaining good health, and not for any particular condition, then your insurer will disregard these check-ups when applying the moratorium.

Your insurer will give you information explaining how their moratorium works. You may also want to ask the insurer or adviser, to explain this.

How do I choose the right cover?

You should check to see if you already have PMI cover. Some employers include PMI as part of their benefits package. A club or professional organisation might also have arrangements to offer you (and your family members) cover.

If this is not the case and you want to take out cover yourself, you need to think about what benefits are most important to you. You will need to decide what sort of cover you want. There are a number of things you will have to consider:

- What are your health requirements?
- How much do you want to spend?
- Are you prepared to pay towards your investigations and treatment?
- Do you want your cover to include seeing a specialist and having diagnostic tests (for example, X-rays and blood tests) as an outpatient?
- Do you want a choice of hospitals, or would you be happy to have any treatment that you might need in a hospital available from a limited range chosen by your insurance company?
- What are you not covered for?

The answers you give to questions such as these could have a significant effect on how much you pay (see section 9). The more your cover includes, the higher your premiums are likely to be. Most policies offer cover for inpatient and day patient treatment, but do not always include cover for outpatient treatment and diagnostic tests.

The following diagram is an example of how you might get private treatment.

Visit your GP

Your GP refers you for investigations or treatment*.

GP refers you for specialist treatment

This usually includes initial consultations and diagnostic tests.

Your specialist needs to refer you to hospital for more investigations or treatment.

Outpatient treatment

Hospital

This may be a private hospital or private facilities within an NHS hospital.

After leaving hospital you will usually have a follow-up visit to your specialist.

Inpatient or Day patient treatment

Follow-up visit

Specialist consultation and a review of your treatment.

Outpatient treatment

*Call your insurance company to check that you are covered for the specialist and hospital treatment, and to discuss your options for accessing care. Remember to stay in touch with your insurer at each stage of your treatment.

Start to claim

If your policy includes outpatient treatment and your claim is eligible, you can claim after your GP has referred you to a specialist.

HOW YOU RECEIVE TREATMENT FALLS INTO ONE OF THREE CATEGORIES.

Outpatient

A patient who attends a hospital, consulting room, or outpatient clinic and is not admitted as a day patient or inpatient.

Day patient

A patient who is admitted to a hospital or day patient unit because they need a period of medically supervised recovery but does not stay in a bed overnight.

Inpatient

A patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.

What is and is not covered?

Private medical insurance is designed to cover treatment for curable, short-term illness or injury. These are commonly called 'acute conditions'. Some long-term illnesses and treatments are rarely covered.

Private medical insurance is not designed to cover the long-term treatment of chronic conditions for a number of reasons:

- The private-hospital sector's main purpose is to treat conditions that can be cured, or mostly cured, quickly.
- A large part of the NHS's funding is to care for patients with long-term conditions. So, for example, patients with diabetes can go to clinics, be regularly monitored and have their insulin needs met. This will often happen locally, in a primary-care setting such as their GP surgery.

As well as the practical reasons mentioned above, insurers also have to balance how much cover they provide with what you are willing to pay for that cover. So, insurers do not usually cover the treatment of long-term (chronic) conditions. This is because, if they did, their premiums would become too expensive for most people.

WHAT YOUR PMI MIGHT COVER

Usually included	Inpatient tests	Surgery as an inpatient or day patient	Hospital accommodation and nursing care	Cash payment to the customer for treatment received as an NHS inpatient
Sometimes included (as part of the policy or if you ask for it)	Outpatient tests	Outpatient consultations and treatment with a specialist	Therapy, for example, physiotherapy and complementary therapy	

The following conditions or treatments are normally not included in your cover:

- Consultations with a general practitioner (GP)
- Accident and Emergency admissions
- Drug abuse
- HIV/AIDS
- Normal pregnancy
- Gender reassignment
- Mobility aids, such as wheelchairs
- Organ transplant
- Injuries you get from dangerous hobbies (often called 'hazardous pursuits')
- Conditions you had before taking out the insurance (commonly known as 'pre-existing conditions' – see section 5)
- Long-term treatment and chronic conditions
- Dental services
- Prescription drugs and dressings, after leaving hospital or as an outpatient
- Deliberately self-inflicted injuries
- Infertility
- Cosmetic treatment
- Experimental or unproven treatment or drugs
- Kidney dialysis
- War risks

Your insurer will provide you with the terms and conditions of your policy at the point of sale or as soon as possible thereafter, but in any event before the conclusion of the contract. Your insurer may also give you a policy summary before or straight after your insurance contract starts. The summary of your policy is designed to highlight any important or unusual limits of the policy, as well as the main monetary limits. Please read your full policy document as the summary will not explain the full policy terms and conditions.

What if I have a disability?

You will not be refused cover because you have a disability. As with other pre-existing conditions, your insurer might not include cover for treatment that is needed because of your disability. However, the law requires that it must be reasonable and fair for them to do this.

If you sign a declaration about your medical history, you must give all relevant information about your disability. If your policy does not cover pre-existing conditions, an existing medical condition causing the disability, or arising from it, will not be covered.

How could my product change over time?

When taking out a PMI policy, and upon renewal, check that you have the right cover in place to meet your needs. Over time your product may change for a number of reasons such as:

- Methods used to diagnose conditions become more advanced and are used more, so doctors are able to identify some conditions earlier and patients can be treated more quickly
- New drugs, such as those for the treatment of cancer, become available
- The technology used in surgery becomes more advanced
- As you get older you are more likely to need treatment; your premiums could increase with your age to reflect this

Insurers take into account a number of factors to assess your risk, to provide you with the best cover at the best price. Depending on changes to your risk profile and any evolution in the cover provided, the premiums you pay may change at renewal.

What if I want to change to a new insurer?

You can change your PMI provider. If you want to switch to a different insurer there are four main things you need to consider.

COMPARING YOUR COVER

Even if your personal medical exclusions stay the same with your new insurer, the overall cover is likely to be different.

You should:

- compare the benefits of each insurer
- compare any cover limits or monetary amounts
- ask questions about how the cover works, including your options to access care

PAPERWORK

Paperwork varies from one company to another, but there is likely to be an application form to sign and you might need to provide a copy of the policy certificate from your current insurer as proof of your current cover.

WHEN YOU CHOOSE TO SWITCH

Usually, private medical insurance is offered through an annual contract. If you are thinking of switching to another insurer, it is best to consider doing this at your renewal date, otherwise you may incur a fee for switching provider before the insurance contract has come to an end.

PRE-EXISTING CONDITIONS

Some insurers will keep your current personal exclusions (what is not included in your cover) which means any treatment for these conditions will be excluded from your new cover. They will not add any new ones. However, some insurers might not cover illnesses or injuries you have had in the recent past or any condition that you suffer from now, even if these are covered by your current insurer. You should compare the benefits, policy terms and cover limits from different providers carefully, so that you get the cover that is right for you.

What do I need to remember?

Before you change insurers you should check the benefits, policy terms and underwriting position carefully to understand the consequences. The cover offered may not be the same.

Check that you have the cover that is right for you. Remember that you may have a choice of options.

You must give full and accurate information to your insurer or adviser. If you do not, your insurer may reduce your claim or refuse to pay and cancel your policy.

You should read all the policy documents carefully, now and in the future. Keep all documents safe.

You need to keep your payments up to date. If you do not, your cover will stop and only eligible treatment costs from before the cancellation date will be paid.

You will be sent details of changes to benefits, rules, premiums in the previous year and proposed premiums for the forthcoming year before your renewal date. Your policy will not be cancelled just because you have claimed or your health has got worse.

What protection do I have?

REGULATION

The Financial Conduct Authority (FCA) and the Prudential Regulation Authority (PRA) regulate private medical insurance policies and any advice you receive about them.

COMPLAINTS

If you are unhappy with the way you have been treated by an insurer when taking out an insurance policy or when making a claim, you can make a complaint directly to the insurer.

If you are not happy with the insurer's response, you can take your complaint to the Financial Ombudsman Service (FOS), an independent body which aims to settle complaints between consumers and businesses providing financial services. More details on the FOS can be found on their website: **www.financialombudsman.org.uk**.

COMPENSATION

The Financial Services Compensation Scheme (FSCS) is the UK's legal fund for customers of authorised financial services firms. The FSCS can pay compensation if a firm cannot, or is likely to be unable, to pay claims against it due to insolvency. The FSCS is an independent organisation, set up under the Financial Services and Markets Act 2000.
Website: **www.fscs.org.uk**

CONFIDENTIALITY

Under current legislation, all insurers treat personal sensitive information confidentially, including medical details. When you are asked for information, you will be told what it will be used for, who it may be given to and in what circumstances. You can ask to see any information an insurer has about you.

Anonymised aggregated statistical information is sometimes given to outside organisations, so they can carry out research.

Insurers might use email to communicate with you. If you choose to communicate with your insurer in this way, you must make sure your email address is private and cannot be used or seen by anyone else.

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