Private Health Insurance

Policy Document

Kindred
For Families. From Doctors.

Classified - Confidential

Kindred

Private Health Insurance

This policy summarises the main features, benefits and exclusions of Kindred Health Insurance. It must be read as a whole and in conjunction with the Membership Guide. The purpose of the policy is to provide cover for consultations and treatment for acute conditions, on a short-term basis, on the recommendation of your GP. The Membership Guide will provide you with details of who is covered under this policy, details of any excess and specific exclusions which apply. It also details what to do if you want to make a claim and who to call if you need help.

Please read both this document and your schedule carefully to ensure that you are familiar with the cover and the terms, conditions and exclusions that apply. If any details are incorrect, please let us know straight away and we will send you replacement documents as applicable. Please keep this document in a safe place.

We use certain words throughout this policy which have specific meanings. These appear in bold text. Please refer to the Definitions Section for the meanings of these words.

What is Kindred Health Insurance?

Kindred offers an innovative concept for private health insurance by providing you with access to a unique consultant-led approach to private healthcare provision and services.

Who is eligible to join?

You can take out Kindred Health Insurance if you are between the ages of eighteen (18) and seventy (70) inclusive and resident in the United Kingdom.

Who provides this cover?

Kindred Health Insurance is arranged and administered by Alliance Medical Indemnity Limited on behalf of MS Amlin Underwriting Limited.

Alliance Medical Indemnity Limited are authorised to perform certain acts on our behalf, but this does not affect your rights to make a claim or complaint with us.

What benefits are available under Kindred Health Insurance?

The table of benefits sets out the treatments and consultations that are available under this policy and the maximum amounts that may be claimed Benefits are per insured person per period of insurance unless stated. The maximum amount payable per insured person per period of insurance is GBP 5,000,000.

You should review your insurance periodically to check that this cover still meets your needs. It is up to you to ensure that the cover you have selected is appropriate for your needs. We cannot advise you on whether this policy meets your personal objectives, financial situation or needs.

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Private Health Insurance

How soon can I make a claim?

This policy holds a 14-day **waiting period**, this means that from your policy start date you are unable to make/register any claims. We understand that waiting periods can be an inconvenience, and we appreciate your understanding and patience. Please rest assured that once this period is over, you will have full access to the benefits outlined in your policy.

What excess payments do I have to pay?

There is no compulsory excess on this policy. However, you may choose to have an excess to reduce your premiums. If you do, the excess amount will be stated in your Membership Guide. This is payable per insured person on their first claim during the period of insurance.

Your excess is payable only once per claim provided the claim is under twelve (12) months in duration. Therefore, where a claim is started towards the end of the period of insurance, you will not be expected to pay a second excess for that claim unless it carries on for over twelve (12) months.

Benefit requirements

To qualify for benefits the following requirements must be met:

1. All treatment must be under the control of a consultant recommended by us, and be for a specific medical condition.
2. Nursing must be under the direction of a consultant.
3. All expenditure must be reasonable and customary, be necessarily incurred and be wholly and exclusively for the purpose of curing an acute condition that is likely to respond quickly to treatment so as to return the insured person to the state of health they were in immediately before suffering the medical condition.
4. Inpatient expenditure must be incurred in a hospital. Benefits are not payable for any use of hospital accommodation which is arranged or continued for purposes of convalescence, rehabilitation or general nursing, or is mainly for any custodial, supervisory or domestic reasons.

What hospitals can I use?

Your chosen hospital list stipulates which locations are available to you; however, the final decision is made by us unless there is an otherwise valid medical reason. Any locations that are not listed, are not covered by the policy. We will find the most appropriate location for you based on the consultant's specialty, which will normally be within a thirty (30) mile radius of your home. All appointments must be pre-authorised before taking place; failure to obtain authorisation could result in you becoming liable for payment.

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Private Health Insurance

Changing your mind

If, for any reason, you decide not to accept this insurance you have up to fourteen (14) days from the date of receipt of the policy documents or the date on which cover commences, whichever is later, to cancel the policy by contacting us in writing, by post or email, stating that you wish to cancel the cover.

If you exercise your right to cancel within this fourteen (14) day cooling-off period, you withdraw from this contract of insurance. Provided you have not made any claims you will be fully reimbursed for any sums you have paid in connection with this policy. If a claim is paid no refund of premium will be allowed.

If you do not exercise your right to cancel within the fourteen (14) day cooling-off period, the policy will remain in force and all premiums will be payable in accordance with the terms and conditions of the policy.

Changes we need to know about

You must also tell us about any changes to your information and circumstances which occur during the period of insurance. You should notify us in writing whenever any of the following occur:

- You are no longer a permanent resident of the United Kingdom;
- Your partner no longer lives with you;
- A dependent child is no longer in full time education;
- A dependent child is no longer living with you;
- An insured person dies.

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Renewal of the policy

The policy lasts for one (1) year and, providing we still offer this type of insurance, we will automatically renew it unless you notify us that you do not wish to renew.

We will send your renewal documents to you before your policy is due to renew in order to give you time to decide whether to renew the policy or cancel it. We may change the terms and conditions of the policy at the renewal date. If there are changes to the policy, we will let you know before the next renewal date. If you decide to cancel the policy as a result of such changes, you must let us know.

If you wish to make any changes to your policy, for example adding or removing options, please contact us. We will review the claims that we have paid, the medical history and the current health for each insured person when deciding whether you can make these changes.

Your information

We collect and receive your information which we will manage in accordance with data protection law and data protection principles.

We require personal data in order to provide good-quality insurance and ancillary services and will collect the personal data required to do this. This may be personal information such as name, address, contact details, identification details, financial information and risk details. Our full Data Privacy Notice can be found on www.msamlin.com/en/site-services/data-privacy-notice.html. A paper copy of the Data Privacy Notice can be obtained by contacting the Data Protection Officer by email (dataprotectionofficer@msamlin.com) or at the below address:

Data Protection Officer
MS Amlin Underwriting Limited The Leadenhall Building
122 Leadenhall Street
London
EC3V 4AG

Alliance Medical Indemnity Limited will also collect, receive, and use your information in order to issue and administer your policy and answer any queries or complaints you may have. Alliance Medical Indemnity Limited are a data controller for these purposes and has its own responsibilities under data protection laws.

Their full privacy policy which explains the types of information they will use, the purposes for which they will use it and the basis for that use, is available on request from them.

Where you have provided information to Us about another person, for example, a family member you have added to this policy, you should make them aware that you have shared their information with Us and show them this notice.

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Contacting us

Kindred Health Insurance is arranged and administered on our behalf by Alliance Medical Indemnity Limited and communication to Us should be directed to Alliance Medical Indemnity Limited who will also communicate with You on our behalf. Their contact details are:

Kindred Health Insurance, 54 Hagley Road, Birmingham B16 8PE.
Telephone: **0333 015 1202**
Email: hello@kindredhealth.co.uk

When writing or sending an email please help us by quoting your policy number on all correspondence. You can find this on your Membership Guide.

Regulatory detail

About Ms Amlin Underwriting Limited

MS Amlin Underwriting Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and Prudential Regulation Authority. MS Amlin Underwriting Limited is registered in England and Wales under number 2323018. Registered office: The Leadenhall Building, 122 Leadenhall Street,
London, EC3V 4AG

About Alliance Medical Indemnity Limited

Alliance Medical Indemnity Limited is authorised and regulated by the Financial Conduct Authority FCA Firm reference 831527.
Alliance Medical Indemnity Limited is registered in England and Wales under company number: 07655729.
Registered Office: 54 Hagley Road, Birmingham, England, B16 8PE.

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How to claim

When you are referred by your GP please call Kindred on **0333 015 1202**. Calls to and from Kindred may be recorded and/or monitored.

You can also contact our virtual GP service Health Hero on **0345 222 0167** to obtain a referral letter.

Please ask for an open referral and Kindred will select an approved consultant for you. Alternatively, if your GP has given you a named referral, Kindred will check that the consultant is recognised by us. If the named consultant is not recognised by us, we will find an approved consultant for you. If you attend any appointments, procedures, treatments or tests that Kindred has not pre-approved we will not pay their fees and you may be liable for these costs.

Whenever possible Kindred will assess your claim over the telephone but we may require the completion of a claim form. Kindred's experienced claims staff will then talk you through the claims process and advise you what to do next.

You must contact Kindred before any planned treatment or diagnostic tests take place so that they can tell you if:

- the treatment is covered;
- there are any limits or excess that apply to your cover; or
- you need to complete a claim form.

Failure to do so may result in your claim not being covered and you becoming liable for payment.

You need to give Kindred all the information we need to assess your claim, for example:

- a completed claim form if we ask for one;
- any medical reports relating to your treatment;
- previous medical records;
- a report if we need one.

Please remember, we do not cover GP charges or fees for completing a claim form.

If your claim continues for some time, or the symptoms re-occur, we may ask for more details.

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How to claim

Claim payments

We pay all costs in Pound Sterling.

Most hospitals will settle charges directly with us, although some may ask you to pay and then reclaim the money from us. You should check the bill on leaving the hospital or facility.

Sometimes you might be sent the bills first. All you need to do is forward them to Kindred with details of your full name, address and policy number. We will then pay the provider (for example the hospital or consultant) direct for eligible costs.

We do not pay any claims if premiums are not paid up to date at the time your treatment takes place.

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Definitions

Where the following expressions appear in the policy, either in single or plural form, they have the meaning set out below. Where the singular is used, this shall include the plural and vice versa.

1. Acute condition

A medical condition that is likely to respond quickly to treatment so as to return you to the state of health you were in immediately before suffering the medical condition or which leads to your full recovery.

2. Benefit

The costs and charges incurred for treatment or consultations that we will pay for under this policy as described in the table of benefits.

3. Cancer

A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

4. Cancer Drugs

Cancer drugs, including Immunotherapy, must be prescribed with curative intent, and we will not cover non established treatments. All drugs/treatments must be licenced for approved use by the National Institute for health and care excellence (NICE) or The Medicine and Healthcare Products Regulatory Agency (MHRA) at the point the treatment is recommended/prescribed.

5. CBT therapist

A cognitive behavioural therapy therapist or counsellor registered with the British Association for Behavioural & Cognitive Psychotherapies.

6. Chemotherapy

The treatment of cancer with chemotherapeutic agents, including all drugs and related diagnostic tests.

7. Chiropractor

A practitioner of Chiropractic who is included in the Register of Chiropractors kept by the General Chiropractic Council.

8. Chronic condition

A disease, illness, or injury that has one or more of the following characteristics:

a. it needs ongoing or long-term monitoring through consultations, examinations, check- ups, and/or tests;

b. it needs ongoing or long-term control or relief of symptoms;

c. it requires rehabilitation or for the patient to be specially trained to cope with it;

d. it continues indefinitely;

e. it has no known cure;

f. it comes back or is likely to come back.

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We do not consider cancer or mental health conditions as chronic conditions.

9. Congenital abnormalities

Disorders or medical conditions present at birth.

10. Consultant

An appropriately qualified medical practitioner recommended by a GP or surgeon as being required for advice, treatment or rehabilitation.

11. Day patient

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

12. Dental treatment

Any dental condition or dentistry, including oral-surgical procedures, gum conditions (periodontal treatment) and malocclusion (orthodontic treatment).

13. Dependant

A partner and any dependent child aged:

a. under twenty-one (21) at the time of the commencement of the Period of Insurance and is normally resident at your address, or;

b. is in full time education and is under the age of twenty-six (26) at the commencement of the Period of Insurance.

14. Diagnostic tests

Investigations, such as x-rays, pathology tests, radiology tests or blood tests, to find or to help find the cause of the symptoms.

15. Eligible appliance

A post-operative knee brace which is an essential and integral part of a cruciate ligament repair, or a post-operative spinal support device which is an essential and integral part of surgery to the spine.

16. Eligible prosthesis

A device which is intended to remain permanently part of the body and is surgically implanted solely for one or more of the following purposes:

a. replacing:

i a joint or ligament;or

ii one or more heart valves; or

iii the aorta or an arterial blood vessel; or

iv a sphincter muscle; or

v the lens or cornea of the eye; or

b. the control of urinary incontinence; or

c. the control of the electrical pathways of the heart; or

d. the relief of raised intra-cranial pressure.

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17. Excess

The amount each insured person must pay towards the cost of an eligible treatment received during the period of insurance.

18. General practitioner (GP)

A medical practitioner who is registered by the General Medical Council.

19. Hazardous pursuits

a. Abseiling, bungee-jumping or hang-gliding,

b. horse racing or hunting on horseback, equine endurance racing, point to point racing, show jumping or polo,

c. any form of racing except on foot or on bicycle powered by foot power only,

d. ice hockey, mountaineering and rock climbing,

e. any form of aerial flight (except as a passenger or crew member travelling on a fully licensed standard type aircraft owned and operated by a recognised airline over an established route),

f. parachuting and parascending, pot-holing, scuba or sub aqua diving, skiing (both on snow and dryslope),

g. water-jet, surf boarding, white water rafting or any other water sport,

h. Any injuries or illnesses resulting from or related to a sport in which the insured person participates as a professional or semi-professional will not be covered by the policy.

20. Home nursing

Treatment that takes place in the insured persons home or other place where they are convalescing immediately following the treatment the insured person received as an inpatient or day patient that is covered by your policy. Treatment must;

a. be recommended and supervised by your consultant; and

b. be carried out by a nurse and be a type only a nurse can provide; and

c. be needed for medical reasons and not to help your mobility, personal care or preparation of meals.

21. Hospital

A medical facility which operates for the care and treatment of sick and injured persons as inpatients and which has specialist facilities to carry out major surgical operations. The hospital must hold a licence as a hospital where licensing is required.

22. Hospital charges

Fees and charges levied by a hospital for treatment as an inpatient or day patient, including:

a. hospital accommodation, which primarily relates to bed charges, meals and refreshments, and nursing care;

b. operating theatre fees;

c. surgeon, physicians and anaesthetist fees;

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d. charges for diagnostic tests, electrocardiograms (ECG), computerised tomography (CT) scans, magnetic resonance imaging (MRI), Positron emission tomography (PET) scans and the interpretation of results by a consultant;

e. ancillary charges, namely charges for admission, resident medical officer, consultations, drugs, dressings,

f. eligible appliances and eligible prostheses used by a consultant as an integral part of a surgical procedure.

23. Injury

A specific, sudden and unforeseen burn, laceration, fracture, dislocation or other trauma that results from an accident which occurs during the period of insurance.

24. Inpatient

A patient who is admitted to hospital and who occupies a bed for one or more nights solely for medical reasons.

25. Insured person

Anyone named as an insured person in the schedule, being either you or a dependant.

26. Medical condition

Any disease, illness or injury and/or associated symptoms, other than a chronic condition.

27. NHS

The National Health Services of England, Northern Ireland, Scotland and Wales.

28. NHS cash benefit

A benefit payable for each night spent as an inpatient under the care of the NHS for elective surgery only, without charge whilst eligible treatment takes place.

29. Non-eligible prosthesis

A device, other than an eligible prosthesis, to replace or augment a missing or impaired part of the body.

30. Nurse

A qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.

31. Oral surgery

Surgery performed in a hospital by an oral and maxillofacial surgeon and the surgery is not in respect of any dental condition (other than the reinsertion of teeth following injury, the removal of impacted wisdom teeth and treatment of jaw cysts when performed by an oral surgeon) or irreversible bone disease related to gum disease or damage.

32. Osteopath

A practitioner of Osteopathy who is included in the Register of Osteopaths kept by the General Osteopathic Council.

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33. Outpatient

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

34. Partner

A spouse, civil partner or someone who lives with you as if they were a spouse or civil partner.

35. Parent accommodation

Accommodation for a parent to accompany a child under the age of sixteen (16) in the same hospital when it is considered medically necessary.

36. Period of insurance

The period stated in the Membership Guide.

37. Physiotherapist

A practitioner of physiotherapy who is included in the Register of the Health and Care Professions Council as a physiotherapist.

38. Podiatrist

A practitioner of Podiatry who is registered with the Royal College of Podiatry.

39. Policy

This policy document, the application and the schedule, including any endorsements attaching thereto.

40. Pre-existing condition

Any medical condition for which:

a. you have received medication, advice or treatment; or

b. you have experienced symptoms;

whether the condition has been diagnosed or not prior to the period of insurance.

41. Preventative treatment

Treatment to remove un-diseased tissue to prevent potential future disease, illness or injury.

42. Radiotherapy

The use of ionising radiation, for whatever recommended reason, for the treatment and/or control of cancer.

43. Surgical procedure

An operation or procedure which is recommended and approved by a consultant to relieve or cure a disease, illness or injury.

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Definitions

44. Table of benefits

The table of benefits in the Cover and Benefits Section of this policy which sets out the benefits available under this policy.

45. Therapist

Chiropractors, osteopaths, physiotherapists or podiatrists employed by a hospital or a private practice for the provision of rehabilitation treatment.

47. United Kingdom

Great Britain, Northern Ireland, the Channel Islands and the Isle of Man.

48. Waiting period

Refers to a specified span of time that must pass before benefits of the policy become effective. During this period, we will not cover any new conditions. This period typically starts from the date the policy is activated.

49. We/our/us

MS Amlin Syndicate 2001 at Lloyds, and where the context requires, Alliance Medical Indemnity Limited.

50. You/your

The Insured stated in the Membership Guide.

You must contact Kindred before any treatment or diagnostic tests take place and must have received authorisation from Kindred before commencing the treatment or diagnostic test.

The table of benefits below shows the categories of benefits, the available cover amounts and any limits applicable to each individual benefit. Benefits are per insured person per period of insurance unless stated. The maximum amount payable per insured person per period of insurance is GBP 5,000,000.

If you have elected to have an excess applied to your policy this will be stated in the schedule. The excess will be payable on the first claim made by each insured person.

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Cover and benefits

Significant features and benefits

Inpatient and day patient benefits

Hospital accommodation and nursing care	Cost paid in full
Operating theatre fees	Cost paid in full
Surgeon, physician and anaesthetist fees	Cost paid in full
Diagnostic tests including ECG, CT, MRI and PET scans	Cost paid in full
Ancillary charges, namely charges for admission, resident medical officer, consultations, drugs, dressings, therapists	Cost paid in full
Eligible appliance and eligible prosthesis	Cost paid in full
Oral surgery (non dental other than reinsertion of teeth following injury, the removal of impacted wisdom teeth and treatment of jaw cysts when performed by an oral surgeon)	Cost paid in full

Outpatient benefits

Consultant consultations, diagnostic tests	Cost paid in full
ECG, CT, MRI and PET scans	Cost paid in full
Physiotherapy	Max ten sessions through physio partner only
Chiropractic, osteopathy, podiatry	Full refund on consultant referral Six (6) sessions on GP referral

Other benefits

NHS cash benefit	£200 per night up to thirty five (35) nights per policy
Private ambulance	Cost paid in full
Home nursing	Cost paid in full
Parent accommodation	Cost paid in full for one parent
Cognitive behavioural therapy	Cost paid in full

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Cover and benefits

Significant features and benefits

Inpatient and day patient cancer benefits

Diagnostic tests including ECG, CT, MRI and PET scans	Cost paid in full
Consultations	Cost paid in full
Radiotherapy and chemotherapy	Cost paid in full
Hospital accommodation and nursing care	Cost paid in full
Surgeon, physician and anaesthetist fees	Cost paid in full
Ancillary charges, namely charges for admission, resident medical officer, consultations, drugs, dressings,	Cost paid in full

Outpatient cancer benefits

Specialist Consultations	Cost paid in full
Diagnostic tests including ECG, CT, MRI and PET scans	Cost paid in full
Specialist **cancer** drugs	Cost paid in full

Inpatient and day patient benefits

Subject to the terms, conditions and exclusions contained in this policy we will pay consultant fees and hospital charges incurred by an insured person for surgical procedures during the period of insurance in accordance with the table of benefits.

Conditions applicable to inpatient and day patient benefits

1. We will only pay fees for a consultant who we have agreed to prior to the insured person's first consultation.
2. We will only pay hospital charges incurred at a hospital which we have agreed to prior to the admission of the insured person. If our preferred hospital is more than thirty (30) miles away from the insured home address, or there is a medical necessity, we may agree to the use of another hospital.
3. We will only pay hospital accommodation charges if a hospital room is being used solely for an insured person receiving inpatient or day patient treatment which they are eligible for.
4. We will pay for consultant fees for a surgical procedure forming part of inpatient or day patient treatment.
5. We will pay for consultant fees for inpatient or day patient treatment if the treatment does not include a surgical procedure.
6. We will only pay consultant fees for their attendance at a surgical procedure if their attendance is medically necessary because of the surgical procedure.

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Cover and benefits

7. We will only pay hospital charges for diagnostic tests when recommended by a consultant to help determine or assess the condition of the insured person when carried out in a hospital as part of inpatient or day patient treatment.
8. We shall pay hospital charges for treatment provided by therapists if it is needed as part of inpatient or day patient treatment.
9. We will only pay for appliances provided by a hospital during inpatient or day patient treatment.
10. While we do not pay for treatment of chronic conditions, we will pay for surgical procedures for a flare-up of acute symptoms of a chronic condition if the treatment is likely to quickly lead to a complete recovery rather than prolonged treatment. Where it is not clear that a condition is a chronic condition and we have paid for its treatment, that does not mean that we will continue paying when we have more information which, in our reasonable view, confirms that it is a chronic condition. You can ask us if a condition is covered.

When you are receiving in-patient or day patient treatment, in making our decision on whether your condition is, or has become, a chronic condition, we will consider the period of days during which there has been no change in your clinical condition or change in your treatment.

Exclusions applicable to inpatient and day patient benefits

We shall not pay for:

1. alcoholic refreshments, cosmetics or personal laundry services;
2. hospital accommodation if it relates to an overnight stay for treatment which would normally be provided as outpatient treatment or day patient treatment, or if an insured person occupies a bed in a hospital for treatment that would normally be provided as outpatient treatment unless such stay or use is deemed necessary by the consultant;
3. extra nursing services, being nursing in addition to that which the hospital would usually provide, without making any extra charges, as part of its normal patient care;
4. travel costs to or from a hospital;
5. an eligible prosthesis, a non-eligible prosthesis, an eligible appliance or any other appliance charged for or supplied by a consultant;
6. any consultations or treatments carried out as an outpatient;
7. a residential stay in a hospital arranged wholly or partly for domestic reasons, or which is not directly related to the treatment of a medical condition.

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Cover and benefits

Outpatient benefits

Subject to the terms, conditions and exclusions contained in this policy we will pay the consultant and therapist fees incurred by an insured person for consultations and treatment carried out as an outpatient during the period of insurance in accordance with the table of benefits.

Conditions applicable to outpatient benefits

1. We will only pay fees for a consultant who we have agreed to prior to the insured person's first consultation.
2. We will only pay for consultations carried out as private outpatient treatment with a consultant to assess an insured condition.
3. We will only pay for diagnostic tests, ECG, CT, MRI and PET scans when recommended by a consultant to help determine or assess the insured person's condition as part of outpatient treatment. We will only pay for ECG, CT, MRI and PET scans carried out at locations we have approved of prior to the scan being performed.
4. We will pay for outpatient treatment provided by therapists upon the referral of a consultant or GP and the therapist must be agreed by us prior to the commencement of treatment. The maximum amount we will pay in respect of therapists depends upon whether the referral was by a consultant, in which case we will pay the full cost, or a GP, in which case we will only pay for a maximum of six (6) sessions. These limits are stated in the table of benefits.

Outpatient benefits

Subject to the terms, conditions and exclusions contained in this policy we will pay the consultant and therapist fees incurred by an insured person for consultations and treatment carried out as an outpatient during the period of insurance in accordance with the table of benefits.

Exclusions applicable to outpatient benefits

We shall not pay for:

1. personal items such as telephone calls, newspapers, meals, alcoholic refreshments, cosmetics or personal laundry services;
2. extra nursing services, being nursing in addition to that which the hospital would usually provide, without making any extra charges, as part of its normal patient care;
3. travel costs to or from a hospital;
4. any consultations or treatments carried out as an inpatient or day patient;

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Cover and benefits

Other benefits

Subject to the terms, conditions and exclusions contained in this policy we will pay for the additional benefits detailed below.

1. NHS cash benefit

Where an insured person chooses to receive inpatient treatment free of charge as a planned admission in a National Health Service (NHS) hospital, and they would have been entitled to reimbursement under this policy if such treatment was received privately, we shall pay you a cash benefit of £200 per night the insured person spent in the NHS hospital subject to a maximum of thirty-five (35) nights per period of insurance. You must provide a claim form stamped by the hospital concerned to confirm that the insured person received treatment as an NHS patient on the dates claimed.

2. Private ambulance

If an insured person is receiving inpatient or day patient treatment for which they are eligible to receive benefits under the terms of this policy, and:

a. it is medically necessary for them to travel between hospitals when the insured person is discharged from one hospital and admitted to another hospital for inpatient treatment; and

b. the transfer is authorised by the consultant responsible for their inpatient or day patient treatment

we shall pay the full cost of an ambulance if one is required for medical reasons.

3. Home nursing

We shall pay full costs for home nursing if:

a. it is recommended and supervised by a consultant that treatment received by an insured patient should take place in the home; and

b. such treatment immediately follows treatment received as an inpatient or day patient that is covered by this policy;

c. such treatment is of a type only a nurse can provide and is needed for medical preparation of meals.

4. Parent accommodation

We shall pay the cost of hospital accommodation for each night a parent needs to stay with their child in hospital provided that the child is an insured person. We will only pay for one parent each night and the child must be aged under sixteen (16).

5. Physiotherapy pathway

When an insured person registers a musculoskeletal claim, such as for back pain or knee pain etc, the claimant must first undergo/partake in a triage call with our physiotherapy partners. During this call, you will receive guidance on the best course of action for your condition/symptoms. If you have already undergone physiotherapy for the same condition outside of the policy, this must be documented in your GP referral letter or Consultant Clinic letter. Please note that we will only cover the cost of physiotherapy provided through our partners; we will not pay for physiotherapy through independent providers.

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Cover and benefits

6. Cognitive behavioural therapy(CBT)

Notwithstanding General Exclusion 18 we will pay the cost of cognitive behavioural therapy provided by a CBT therapist upon the referral of a consultant or GP and the therapist must be agreed by us prior to the commencement of treatment. We will only pay for a maximum of ten (10) sessions. These limits are stated in the table of benefits.

Cancer benefits

Subject to the terms, conditions and exclusions contained in this policy we will pay:

1. consultant fees, fees and hospital charges incurred by an insured person during the period of insurance for the treatment of cancer;
2. a. consultant fees;
   b. fees;
   c. hospital fees and charges for tests and drugs that are specifically related to the planning and carrying out of treatment of cancer as an outpatient;
3. hospital fees and charges for a prosthesis which is surgically implanted for the purpose of reconstructing a breast following surgery for cancer.

Conditions applicable to cancer benefits

1. We will pay for treatment of all stages of cancer where the intent is to affect the growth of the cancer by shrinking a tumour or halting its growth.

   To assess whether your medical condition and treatment are eligible under this policy, we will ask your consultant for some medical information, including what treatment you will be having, the intent of your treatment and the medical evidence to support the effectiveness of your treatment. One of the factors we will take into account when reviewing the intent and effectiveness of your proposed treatment is the statistics on the chances of disease free survival after a five (5) year period.
2. Treatment with drugs such as chemotherapy will be covered where they are used within the terms of the marketing authorisation (otherwise known as its license) as issued by the European Medicines Agency (EMA) or the Medicines and Healthcare Products Regulatory Agency (MHRA). For combinations of drugs, the drugs used must have obtained the appropriate marketing authorisation and must have been shown to be effective in treating the cancer you have and must be approved by The National Institute For Clinical Excellence (NICE).
3. In circumstances where treatment is planned to be given for years, for example some hormone treatments, benefit will be provided for a limited period of three (3) months to allow for the treatment to be established and you to make arrangements to receive the treatment under the NHS. Where hormone treatments are given in the form of tablets, there would be no cover for these as outpatient medication is excluded under this policy.
4. Some treatments are given for prolonged periods of time, such as monoclonal antibodies (for example Avastin or Herceptin). Where this is the case, benefit for the drug will be funded for the period dictated by its marketing authorisation, but up to a maximum of one (1) year (whichever is the shorter period) from the date the drug is first given, either as an NHS or private patient.

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Cover and benefits

5. For the purposes of this benefit one course of radiotherapy is deemed to be up to fifteen (15) attendances for treatment, in connection with which all drugs and related diagnostic tests are covered.
6. If the intent of treatment is to provide relief of symptoms, rather than attempting to affect the growth of cancer, benefit will stop. We will always talk to you and your consultant if this situation arises to ensure the transition from private to NHS healthcare is handled as smoothly as possible.
7. If your cancer comes back, we will assess your medical condition and proposed treatment as a new episode of treatment and will follow the same process in assessing the eligibility of your claim. Where you have a recurrence of cancer we will need to consider how this recurrence has affected the prognosis of your medical condition and chances of disease free survival after a five (5) year period.

As a result, we may have to request specific information from your consultant to determine whether your claim remains eligible for benefit. Where the intent of treatment is to provide relief of symptoms, rather than affecting the growth of cancer over this five (5) year period, benefit will stop.

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General exclusions

We shall not pay for:

1. accident and emergency treatment, or any other medical treatment within an Intensive Care Unit or High Dependency Unit following admission to an NHS hospital for accident or emergency treatment. Once the insured person's condition has stabilised and their consultant has declared them fit enough to be transferred to another facility, they will be entitled to use the benefits available under this policy;
2. treatment for or as a result of any alcohol, drug or substance abuse or any other addictive condition;
3. treatment or monitoring of a chronic condition, other than as provided for in Condition 10. of the Conditions Applicable to Inpatient and Day Patient Benefits;
4. cochlea implants;
5. treatment for congenital abnormalities except for emergency surgical procedures carried out within ten (10) days of birth;
6. cosmetic or aesthetic procedures, whether required for medical or psychological reasons. However, this exclusion will not apply to surgical procedures undertaken for the purpose of restoring an insured previous appearance which has been disfigured as a result of an accident or as a result of surgery for cancer, provided that:
    a. such accident or surgery for cancer took place during the period of insurance;
    b. we will not pay for any surgical procedure or treatment required as a direct or indirect consequence of previous cosmetic or aesthetic treatment ,which was not eligible or paid for under this policy;
    c. payment of benefit is limited to twelve (12) months from the date of the initial reconstructive surgery;
7. treatment for children who are born following assisted conception for the first sixty (60) days following their birth.
8. dental treatment, other than the reinsertion of teeth following trauma, the removal of impacted wisdom teeth and treatment of jaw cysts when performed by an oral surgeon;
9. treatment for development delay, learning and behavioural difficulties or language difficulties;
10. dialysis for chronic renal failure or end stage renal disease;
11. drugs,medicines and dressings other than those prescribed by a consultant for use during or following a surgical procedure or treatment covered under this policy;
12. a. experimental treatment and drugs which are regarded as experimental or unproven based on established medical practice in the United Kingdom;
    b. drugs which are not used within the terms of their marketing authorisation (otherwise known as its license) as approved by National Institute of Clinical Excellence (NICE) or issued by the Medicines Healthcare Products Regulatory Agency (MHRA);
    c. combinations of drugs which have not been proven to be effective in treating the insured medical condition;

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13. treatment for or investigations into:
    a. fertility or infertility conditions;
    b. assisted reproduction;
    c. any type of contraception, sterilisation or reversal of sterilisation;
    d. sexual dysfunction including impotence;
    e. pregnancy, termination of pregnancy or childbirth, ante-natal or post-natal care;
14. Treatment for gender dysphoria including gender reassignment surgery;
15. GP services, including any charges a GP may make for completing a claim form;
16. hormone replacement therapy, unless following the removal of both ovaries when the treatment will be limited to a maximum of two (2) years from the date of removal;
17. treatment of a pre-existing condition;
18. preventative treatment such as health screening, health checks and the like;
19. treatment for psychiatric or psychological conditions or mental illness;
20. routine medical examinations, screenings or tests, including but not limited to hearing and sight tests;
21. treatment of any self-inflicted injury, disability or disease, including treatment related to attempted suicide; treatment or diagnostic tests for:
    a. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immuno-deficiency Virus(HIV);
    b. sexually transmitted diseases;
22. treatment:
    a. for short or long sight, astigmatism or any related condition;
    b. for sleep apnoea, snoring or any other sleep related breathing disorder;
    c. solely to temporarily relieve symptoms, including those symptoms associated with ageing, menopause or puberty;
    d. to desensitise or neutralise an allergic condition or disorder;
23. transplantation operations, including bone marrow and autologous stem cell transfer, donor costs or any related treatment except corneal or skin grafts;
24. treatment for injuries arising out of the participation in hazardous pursuits;

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25. treatment for injuries arising directly or indirectly out of or from:
    a. acts of war and terrorism (whether or not a declaration of war or terrorist act was made), acts of hostility from foreign aggressors including invasion, riots and civil commotion, strikes and lockouts, revolution, mutiny and rebellious acts and usurped power (seizure and maintenance by a person or group of an office of power by force);
    b. the release of weapons of mass destruction, including but not limited to nuclear/ biological and chemical weapons;
    c. the use, misuse, escape or the explosion of any gas or hazardous substance (such as explosives, radiological, biological or chemical agents);
26. treatment received:
    a. in a Health Resort, Nature Cure Clinic or similar establishments;
    b. outside of the United Kingdom.
27. any claim in any way caused by or resulting from:
    a. coronavirus disease (COVID-19);
    b. severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2);
    c. any mutation or variation of SARS-CoV-2;
    d. any other epidemic disease and/or pandemic disease as declared by any government or civil authority
    e. any fear or threat of a), b) or c) above.
28. treatment for or arising from any epidemic disease and/or pandemic disease

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Claims conditions

1. It is important to contact the claims team on **0333 0151 202** before arranging any treatment for assistance and to ensure correct procedures are followed when making a claim. A completed claim form, together with supporting documents, provided at your expense, must be submitted as soon as possible. We have the right to reject any claim which is not submitted within ninety (90) days of the expenditure being incurred.
2. We will only pay hospital charges incurred at a hospital which we have agreed to prior to the admission of the insured person. If our preferred hospital is more than thirty (30) miles away from the insured home address, or there is a medical necessity, we may agree to the use of another hospital.
3. We will only pay fees for a consultant or therapist who we have agreed to prior to the insured first consultation.
4. All the expenditure incurred by an insured person must be solely connected to the normal provision of treatment and should only be with the scope of the hospital charges and benefits that we have agreed to pay as part of a claim.
5. All payments will be made direct to the hospital, consultant, therapist or service provider except for payments in respect of the NHS cash benefit which will be paid to you.

If you have an excess applicable to this policy such excess must be paid to us upon completion of treatment.

6. The claimant must have been eligible at the time of receiving the treatment in respect of which the claim is made.
7. response to a claim, we may:
    a. require a medical report giving such information as we reasonably require, and/or
    b. appoint an independent medical examiner, and/or
    c. require written confirmation from any parties whose charges are being claimed as to their customary levels of charge.
8. If the insured person has any other insurance covering the benefits which have been provided, the Kindred claims team must be notified of that fact in writing at the time of making a claim and we reserve the right to decline payment of a claim in such circumstances.

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Cover and benefits

Claims conditions

1. To be eligible for cover, all insured persons must be:
    a. Under the age of seventy (70) at the commencement of insurance, and
    b. Permanently resident in the United Kingdom.
3. When an insured person reaches their seventieth (70th) birthday cover in respect of them will continue until the expiry of the period of insurance and will not be available to them under any subsequent renewal of this policy.
4. Benefit in respect of each claim is subject to any maximum amounts stated in this policy, up to a maximum aggregate limit of GBP 5,000,000 per insured person per period of insurance.
5. If you have chosen to have an excess under this policy the excess is payable for each insured person on their first claim in the period of insurance. The excess is only payable once per claim provided the claim is under twelve (12) months in duration. If the duration of the claim exceeds twelve (12) months then a further excess will apply at each subsequent twelve (12) month anniversary date of the claim.
6. The policy lasts for one (1) year and, providing we still offer this type of insurance, we will automatically renew it unless you notify us that you do not wish to renew.

We reserve the right to revise or discontinue any or all of the terms, conditions or benefits of this policy from any renewal date. These changes will reflect any past or foreseeable changes in medical practice or procedures and the nature and extent of claims made or likely to be made generally under the policy. Any such changes will be notified to you by be bound by those terms.

We will send your renewal documents to you before your policy is due to renew in order to give you time to decide whether to renew the policy or cancel it. If you decide to cancel the policy as a result of such changes, you must let us know.

If you wish to make any changes to your policy, for example adding or removing options, please contact us. We will review the claims that we have paid, the medical history and the current health for each insured person when deciding whether you can make these changes.

7. The premium is payable either in instalments or annually in advance. We may vary the premium rate applying to the policy at any renewal by giving you written notice. The premiums are subject to Insurance Premium Tax at the current rate and this rate has already been included in the premium payable. Thirty (30) days' notice in writing will be given if the premium payable is affected. If the premium is payable in instalments it is important to continue to pay the premium while benefits are being paid under this policy in order to maintain the cover. In the event that any premium is not paid on the date due, the policy will terminate automatically.

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8. We have relied on the information you have given us. You must take care when answering any questions we ask by ensuring that all information provided is accurate and complete.

If we establish that you deliberately or recklessly provided us with false or misleading information we will treat this policy as if it never existed and decline all claims.

If we establish that you carelessly provided us with false or misleading information it could adversely affect your policy and any claim. For example we may:

a. treat the policy as if it had never existed and refuse to pay all claims and return the premium paid. We will only do this if we provided you with insurance cover which we would not otherwise have offered; or

b. amend the terms of the policy. We may apply these amended terms as if they were in place from the start of the period of insurance; or

c. reduce the amount we pay on a claim in the proportion the premium you have paid bears to the premium we would have charged you; or

d. cancel the policy in accordance with General Condition 7.

We will write to you if we:

e. intend to treat this policy as if it never existed; or

f. need to amend the terms of the policy; or require you to pay more for the policy.

9. You may cancel this policy at any time by giving us thirty (30) notice in writing, quoting your full name, address and policy number. You will not be entitled to any benefits or liable to pay any premiums after the cancellation date.

We may cancel the policy immediately in accordance with Condition 6. above.

Where there is a valid reason we may cancel this policy by giving your thirty (30) day's notice in writing. Examples of valid reasons are:

a. non-payment of premium;

b. a change in risk occurring which means that we can no longer provide insurance cover to you;

c. non-cooperation or failure to supply any information or documentation we requested;

d. threatening or abusive behaviour or the use of threatening or abusive language.

Provided there has not been a claim you will be entitled to a refund of the premium paid, subject to a deduction calculated on a proportional basis for the time you have been covered.

If a claim is paid no refund of premium will be allowed. Cancellation of the policy by us will not affect the treatment of any claim made under the policy in the period before cancellation.

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10. You must give us written notification of any claim or right of action against any party which gives rise to a claim under this policy. You or the insured person must take all steps we reasonably require in making a claim upon that other party. We shall be entitled to pursue in any insured name for our own benefit any claim for indemnity or damages or otherwise which relates to any benefits and costs paid or payable under this policy. We shall have full discretion in the conduct of any proceedings and in the settlement of any such claim, but we shall have no responsibility for any claim for uninsured losses, in respect of which you or the insured person should ensure that legal advice is taken.
11. Currently all benefits under this policy are non-taxable although this may change in line with any amendments to legislation.
12. The benefits under the policy cannot be assigned and the policy has no surrender value.

Waiver by us of any term or condition of this policy will not prevent us from relying on such terms and conditions thereafter.

13. If any claim under this policy is in any respect fraudulent or unfounded, all benefit paid and/or payable in relation to the claim shall be forfeited and recoverable by us.
14. This policy is subject to English Law.
15. This policy provides benefit for treatment incurred during the period of insurance only. In the event that this policy is not renewed, we will cease paying for expenses incurred after the expiry date.
16. We shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.
17. Any benefits under this policy due to:
    a. the use of, or inability to use, any application, software, or programme in connection with any electronic equipment (for example a computer, smartphone, tablet or internet- capable electronic device);
    b. any computer virus;
    c. any computer related hoax relating to a) and/or b) above are payable, subject to the terms, conditions, limitations and exclusions of this policy.

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Complaints procedure

Our aim is to ensure that all aspects of your insurance are dealt with promptly, efficiently and fairly. At all times we are committed to providing you with the highest standard of service.

Should you have any complaint regarding the handling of this insurance or any claim you should write to or telephone Kindred. Please quote either your policy number or claim number in all correspondence.

In the event that you remain dissatisfied and wish to make a complaint with Us, you can do so at any time. Making a complaint does not affect any of your legal rights.

Our contact details are:

Post:	Complaints MS Amlin Underwriting Limited The Leadenhall Building 122 Leadenhall Street London EC3V 4AG
Telephone:	+44 (0) 20 7746 1300
Fax:	+44 (0) 20 7746 1001
Email:	complaints@msamlin.com

If your complaint cannot be resolved by the Complaints Department within two weeks, or if you have not received a response within two weeks you are entitled to refer the matter to will then conduct a full investigation of your complaint and provide you with a written final response.

Lloyd's contact details are:

Post:	Complaints Lloyd's Fidentia House Walter Burke Way Chatham Maritime Chatham Kent ME4 4RN
Telephone:	+44 (0) 20 7327 5693
Fax:	+44 (0) 20 7327 5225
Email:	complaints@lloyds.com
Website:	www.lloyds.com/complaints

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Details of complaints procedures are set out in a leaflet 'Your Complaint - How We Can Help'
www.lloyds.com/complaints and are also available from the above address.

If you remain dissatisfied after Lloyd's has considered your complaint, or if you have not received a written final response within eight weeks from the date we received your complaint, you may be entitled to refer your complaint to the Financial Ombudsman Service who will independently consider your complaint free of charge. Their contact details are:

Post:	The Financial Ombudsman Service Exchange Tower London E14 9SR
Telephone (Fixed):	0800 0234567
Tel (Mobile):	0300 1239123
Tel (Outside UK):	+44 (0)20 7964 0500
Fax:	+44 (0)20 7964 1001
Email:	complaint.info@financial-ombudsman.org.uk
Website:	www.financial-ombudsman.org.uk

To check if you are an eligible complainant or if you are unsure whether the Financial Ombudsman Service will look at your complaint please contact them directly for further information. You are entitled to contact the Financial Ombudsman Service at any stage of your complaint.

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About your insurer

MS Amlin Underwriting Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and Prudential Regulation Authority.

MS Amlin Underwriting Limited is registered in England and Wales under number 2323018.

Registered office:
The Leadenhall Building,
122 Leadenhall Street,
London,
EC3V 4AG

Financial Services CompensationScheme

The insurer is covered by the Financial Services Compensation Scheme. You may be entitled to compensation from the scheme if the insurer is unable to meet its obligations to you under this contract depending on the type of insurance and the circumstances of your claim.

Further information about the Scheme is available from the Financial Services Compensation Scheme (10th Floor, Beaufort House, 15 St. Botolph Street, London EC3A 7QU) and on their website www.fscs.org.uk