Association of British Insurers

Are you buying private medical insurance?

Take a look at this guide before you decide
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1 About this guide

We have designed this guide to help you understand more about what private medical insurance (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.

We publish this guide on behalf of all insurers who offer PMI, whether they are our members or not. The ABI is the recognised trade association that represents insurance companies working in the UK. Our members make up more than 90% of the UK's insurance business.

As well as this guide, the information you receive from PMI companies will tell you more about the products that you are considering buying. They outline what is, and is not, covered.

Remember that products from different companies will vary. If you have any questions, your financial adviser or insurance company will be able to answer them.

Don't confuse private medical insurance with other types of insurance.

Private medical insurance is often called 'health insurance', and can sometimes be confused with other types of insurance such as health cash plans, income protection and critical illness. We publish guides on these types of insurance if you'd like to know more.

2 What is private medical insurance?

Private medical insurance is designed to cover the costs of private medical treatment, for what are commonly known as 'acute conditions' that start after your policy begins.

Most insurers define an acute condition as a disease, illness or injury that is likely to respond quickly to treatment and 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 other conditions, such as cancer and chronic (long-term) conditions.

Why buy private medical insurance?

Most people buy this type of insurance to:

- be reassured, knowing that treatment is available quickly if they become ill or are injured;
- have a choice about when treatment will take place, the specialist who treats them and the hospital; and
- have the privacy of an en-suite room with a TV and other home comforts.

How does private medical insurance work?

Although policies can be different, medical treatment usually has to start with a referral by your GP to an appropriate specialist.

Before you arrange any private treatment, you should call your insurance company to check that you are covered for the treatment. In fact, most insurers need you to do this.

Stay in touch with your insurer at each stage of your treatment. Your insurer will confirm if you are covered. Treatments for some illnesses, including pre-existing conditions (conditions from which you are already suffering, or have already had) will not be covered by a private medical insurance policy (see section 4 of this guide). It is also important to remember that private medical insurance is designed to work alongside, not to replace, all the services offered by the NHS. Some services, such as accident and emergency, are not available at most private hospitals.

3 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; or
- through an agent (bank, building society or retail outlet, such as a supermarket).

You can apply for insurance:

- over the phone;
- face-to-face;
- using the internet; or
- by post.

If you're using the internet, try searching under 'health insurance' as well as 'medical insurance'.

An insurer, or an 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; or
- 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 will probably 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 don't, your insurer may refuse to pay your claim and could cancel your policy.

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. 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.

4 Will I need to give details about my health?

You won't 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; or
- 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 don't, your insurer may refuse to pay any claim that you make in the future, or may cancel your policy.

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. This 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 medical or related condition that you have received treatment for, taken medication for, asked advice on or had symptoms of.

In other words, you will not be covered for any condition that existed in the past few years. Five years is the usual time period.

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, usually for a continuous period of two years after your policy has started.

You do not need to tell the insurer about your medical history when you take out the policy. 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.

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

5 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. Even a club or professional organisation might have arrangements to offer you (and your family members) cover at better rates.

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. When looking at cover, it is useful to know how much medical treatment costs, so you know how much cover to buy.

There are lots of different sorts of policies, from low cost, offering limited cover, to those that offer wide-ranging cover and benefits. Most policies offer cover for inpatient and day-patient treatment, but not always outpatient treatment and diagnostic tests.

You will need to decide what sort of cover you want. There are a number of things you will have to consider.

- How much do you want to spend?
- Do you want to pay for part of your 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 am I not covered for?

The answers you give to questions such as these, could have a significant effect on how much you pay (see section 8). The more your cover includes, the higher your premiums are likely to be. The following diagram is an example of how you might get healthcare.

Visit your GP

Your GP needs to refer you for investigations or treatment.

GP refers you to a specialist

This usually includes initial consultations and diagnostic tests.

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

Follow-up visit

Specialist consultation and a review of your treatment.

Outpatient treatment

Inpatient or Day patient treatment

Outpatient 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.

Healthcare is divided into the following groups.

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 stays in a bed overnight or longer, for medical reasons.

6 What is and is not covered?

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

PMI isn't 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 before, insurers also have to balance how much cover they provide with what you are willing to pay for that cover. So, insurers don't cover the treatment of long-term (chronic) conditions. This is because 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 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	Overseas cover	Therapy, for example, physiotherapy and complementary therapy

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

- Going to a general practitioner (GP)
- Going to Accident and Emergency
- Drug abuse
- HIV/AIDS
- Normal pregnancy
- Gender reassignment (sex change)
- 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 4)
- Dental services
- Outpatient drugs and dressings
- Deliberately self-inflicted injuries
- Infertility
- Cosmetic treatment
- Experimental or unproven treatment or drugs
- Kidney dialysis
- War risks

Your insurer will give you a summary of your policy, or Key Features Document, and a full policy document, either before or straight after your insurance contract starts. The summary of your policy or Key Features Document will set out any important or unusual limits of the policy, as well as the main monetary limits.

7 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, 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 disability, or arising from it, will not be covered.

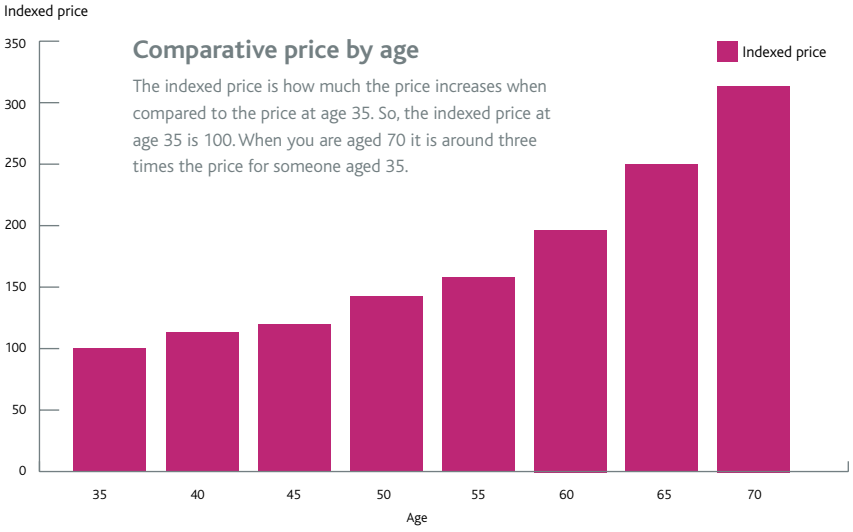
8 Will my premiums increase over time?

Even with the wide range of PMI policies available, it is likely that whatever policy you choose your premiums will rise above the rate of general inflation.

Advances in modern medicine mean that doctors are able to identify some conditions earlier than ever before. For example, a patient who had a heart attack 20 years ago might have been treated with a heart bypass operation. Today they might be offered a pacemaker before a bypass is considered. The cost of healthcare will increase when:

- new drugs, such as Herceptin and Avastin for the treatment of cancer, become available;
- the methods used to diagnose conditions become more advanced, which means patients can be treated more quickly, and are used more; and
- the technology used in surgery becomes more advanced.

PMI tries to keep up with new medical developments, as they become established medical practice. As you get older you are more likely to need treatment. Premiums usually increase with your age to reflect this. The graph below shows how premiums can increase with age. This is only an example and will vary depending on your insurer. You can always ask your insurer to give you advice about their current rates at different ages.



Can I reduce my premiums?

You may be able to reduce your premiums by choosing from:

- a reduced level of benefits, such as limited outpatient cover;
- a specific range of hospitals;
- an excess on your policy, where you pay the first part, say £100, £200 or £500 of any treatment, either each policy year or each claim;
- a policy with 'co-insurance' where you agree to pay a set percentage of any claim and the insurer pays the balance until you have paid an agreed yearly amount (after this the insurer pays 100%);
- a policy that offers a no-claims discount or a discount that depends on your commitment to health, including exercising regularly and not smoking;
- having treatment on the NHS, if this is available within 6 to 12 weeks of being diagnosed, rather than in a private hospital; and
- receiving a discount by changing how you pay.

9 What if I want to change to a new insurer?

You can change your PMI company. If you want to switch, there are four main things you need to consider.

Existing conditions

Some insurers may match your exclusions (what is not included in your cover) and add these to your new cover. They will not add any new ones. However, some insurers might not cover illnesses or injuries you have had in the past or any condition that you suffer from now, even if these are covered by your current insurer.

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; and
- ask questions about how the cover works.

Paperwork

Paperwork varies from one company to another, but there's 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's best to consider doing this at your renewal date. At any other time, check if you will lose any payments.

10 Points to remember

- You must give full and accurate information to your insurer or adviser. This will avoid your claim being refused or your policy being cancelled.
- You should read all the policy documents and terms carefully, now and in the future. Keep all documents safe.
- You need to keep your payments up to date. If you don't your cover will stop and only eligible treatment costs from before the cancellation date will be included.
- If your policy is a yearly contract, you will be sent details of changes to benefits, rules or premiums before your renewal date. Your insurer cannot cancel your policy just because you have claimed or your health has got worse.
- 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.

11 How is private medical insurance regulated?

Financial Services Authority

The Financial Services Authority (FSA) was set up by the Government to provide a single regulator for financial services. The FSA is committed to protecting you and promoting your understanding of the financial system. The FSA has a list of authorised companies.

The FSA regulates insurers, independent intermediaries (sometimes called insurance brokers) and advisers. The FSA has set out rules about the selling and providing of general insurance. These rules must be followed by those dealing with you. Website: **www.fsa.gov.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. The FSCS is an independent organisation, set up under the Financial Services and Markets Act 2000. This service is free. Website: **www.fscs.org.uk**

Confidentiality

By law, specifically the Data Protection Act 1998, all insurers have to treat sensitive and personal information confidentially, especially 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 we have about you.

Totally anonymous 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.

Complaints

All insurers, and anyone else advising on private medical insurance, must have their own complaints procedures in place. They must also be covered by the Financial Ombudsman Service (FOS). This means that if you have a problem with any part of your cover, you should speak to your insurer or adviser first. If you are not happy with the way your complaint is handled, the FOS offers an independent service to help settle your dispute. This service is free. **www.financial-ombudsman.org.uk**

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