



Exeter Care
Preferred Plan &
Low Cost Plan

Policy Document
January 2009



Exeter Friendly
Society

Private Medical Insurance
UK & International

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Introduction

Thank you for choosing Exeter Friendly Society as your private medical insurer. This booklet sets out the private medical insurance cover available to you as a **member** of either the Exeter Care Preferred or Low Cost Plan. It also contains the full current rules, together with definitions of some of the terms used, and explains how to make a claim.

Please take a little time to read this booklet, together with your **Policy Certificate** and **Hospital Choice List**. If anything is unclear to you, please call **Customer Support** on 0300 123 3200 (Monday to Friday 9am - 5pm) who will be happy to help you. The information in this Policy Document is valid only for cover from 1 January 2009. Amendments to its terms for renewals in subsequent **years** will be notified to **policyholders** with renewal documentation.

Definitions

Where the following words or expressions appear in this document, they have the specific meaning set out below. To help you identify these words or expressions, they are shown in **bold italics** throughout this document, and may be referred to in the singular and/or plural. Where a person is referred to in the masculine, it includes persons of both genders.

Accommodation

The charge made by a hospital for **in-patient treatment** or **day-patient treatment**. The charge includes the cost of the bed, meals, routine nursing and housekeeping.

Acute Condition

A disease, illness or injury that is likely to respond quickly to **treatment** which 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.

Benefit

The amount that may be payable by **us** under the **policy** in respect of any eligible claim.

Cancer

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

Chronic Condition

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

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

Customary And/Or Reasonable Fees

By **customary and/or reasonable fees we** mean the expected fees charged for **treatment**, facilities or equipment in the country or locality in which they are received, based on the fees charged to the majority of **our members** for those services in that location.

Day

A period of 24 hours.

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 occupy a bed overnight.

Diagnostic Tests

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

Emergency Admission

An unplanned admission to any hospital (either NHS or private) including (but not limited to) any admission arising from, and within a **day** of, a consultation with a primary carer or **specialist**.

Excess

An amount of eligible **benefit** that is waived by a **policyholder** for each **member** in a **year** in return for a reduced **premium**.

See how **excesses** work in the examples on pages 12-15 and rule 6.5 on page 35.

Family Member

Your partner and **your** unmarried children (and those of **your** partner) under the age of 21 at the commencement of cover or any subsequent **renewal date** and who are included on **your policy**. By partner, **we** mean **your** husband or wife or the person with whom **you** live permanently in a similar relationship. By children, **we** mean any child for whom **you** or **your** partner holds the position of a legal guardian.

Home Nursing

Skilled nursing by a qualified **nurse** at home immediately following **in-patient treatment** or **day-patient treatment**. The nursing must be recommended and supervised by the **specialist** who treated the **member**, and required for medical as opposed to domestic reasons.

Hospice

A dedicated facility for patients with advanced progressive incurable disease, which attends to the physical, psychological and spiritual needs of the patient and those close to them.

Hospital Choice List

A document published by the **Society**, which lists the hospitals whose charges are eligible for **benefits** under your **plan**.

In-Patient

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

Member

You and any **family member** included in your **policy** and named on your **Policy Certificate**.

Nurse

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

Oncology

The specialist **treatment** of **cancer**, which includes radiotherapy and chemotherapy. The **specialist** is called an oncologist.

Orthoses

Additional equipment designed to be used externally, including but not limited to the following: shoe inserts, neck supports and wrist braces.

Out-Patient

A patient who attends a hospital, consulting room, or out-patient clinic and is not admitted as a **day-patient** or an **in-patient**.

Overseas

Outside the **United Kingdom**.

Plan

Any one of the private medical insurance schemes provided by the **Society**.

Policy

The written agreement with the **Society** under which you are entitled to claim **benefits** contained in the documents listed in rule 1.1.

Policy Certificate

The document issued by the **Society** as evidence of your **policy**.

Policyholder

The person who has taken out the **policy**, and is identified as such on the **Policy Certificate**.

Pre-Admission Tests

A clinical assessment required to determine a patient's fitness and suitability for anaesthesia and surgery, which may also detect unsuspected conditions that might affect the patient's surgery. These tests are not diagnostic.

Pre-existing Condition

Any disease, illness or injury, for which:

- you have received medication, advice or **treatment**; or
- you have experienced symptoms;

whether the condition has been diagnosed or not in the five years before the start of your cover.

Premium

The amount payable to the **Society** for **members** to belong to a **plan**.

Primary Care Physician

A General Practitioner (GP), Optician or Dentist.

Professional Sport

A sport where a fee or benefit in kind is received, paid or made available, either directly or indirectly, for playing, training or any other reason.

Prosthesis

An internal, permanent replacement of a missing body part but specifically excluding artificial limbs, artificial heart pumps or cochlear implants.

Reasonable And/Or Customary Fees

See **Customary And/Or Reasonable Fees**.

Renewal Date

The anniversary of when the **policy** began, or any other date determined by the **Society**.

Society

Exeter Friendly Society Limited.

Specialist

A healthcare professional to whom a **member** is referred by his General Practitioner (**primary care physician**) for secondary care. This person must have the appropriate qualifications and be on the GMC Specialist Register, or equivalent **overseas** and must belong to a recognised professional regulatory body.

Treatment

Surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

United Kingdom (UK)

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

We/Our/Us

Exeter Friendly Society Limited.

Year

A period of twelve calendar months from the date the **policy** began or from any subsequent **renewal date**.

You/Your

When printed in **bold italics**, **you/your** refers to the **policyholder**. When printed in plain type, **you/your** refers to any of the persons included on the **policy**.

Language Used and Law Applicable

When providing services under your **policy**, the language **we** will use will be English. In accepting **our** service you agree that the law of England and Wales will determine the establishment and performance of your **policy**, subject to **our** compliance with any local regulation or legal requirements. In respect of performance and formation of this arrangement, you agree that the courts of England and Wales have exclusive jurisdiction.

Demands and Needs Statement

Preferred Plan

The Preferred Plan meets the demands and needs of a person resident in the **UK** who is looking to insure against the costs of private **treatment**, received on an **in-patient** or **day-patient** or **out-patient** basis, for **acute conditions** that originate after joining the **Society**.

If selecting the Preferred Plan you acknowledge that cover is not available for the **treatment** of medical conditions that the **Society** deems as chronic in nature, nor for the conditions listed as not covered in section 8 of the rules contained within this Policy Document.

You also recognise that cover is limited according to the Table of **Benefits** and rules described in this Policy Document and that, therefore, in certain circumstances, the **benefits** available may not fully cover the costs of **treatment**.

If taking one of the voluntary **excess** options in order to reduce the **premium** payable, you accept that the **benefits**, which would otherwise be payable in respect of each person covered by your **policy** in any **year**, will be subject to a deduction equal to the amount of **excess** taken.

Low Cost Plan

The Low Cost Plan meets the demands and needs of a person resident in the **UK** who is looking to insure against the costs of private **treatment**, received on either an in-patient or day-patient basis, of **acute conditions** that originate after joining the **Society**.

If selecting the Low Cost Plan you acknowledge that cover is not available for the **treatment** of medical conditions that the **Society** deems as chronic in nature, nor for the conditions listed as not covered in section 8 of the rules contained within this Policy Document, and that the amount of **benefit** available for **out-patient** services and **diagnostic tests** is very restricted.

You also recognise that cover is limited according to the Table of **Benefits** and rules described in this Policy Document and that, therefore, in certain circumstances, the **benefits** available may not fully cover the costs of **treatment**.

If taking one of the voluntary **excess** options in order to reduce the **premium** payable, you accept that the **benefits**, which would otherwise be payable in respect of each person covered by your **policy** in any **year**, will be subject to a deduction equal to the amount of **excess** taken.

Other Products

If your demands and needs have changed since you took out your current cover, or are no longer met by the terms of your **policy**, please call **us** on 0300 123 3200 and ask for the **Policy Review Team** or, if applicable, consult with the intermediary who arranged your **policy**.

The **Society** has a range of Private Medical Insurance plans available that may be more suitable for you including the following:

Shared Care - A flexible **plan** for residents of the **United Kingdom** where the insured agrees to cover a portion of eligible **treatment** costs in return for a significantly reduced **premium**.

Interplan Euro - A **plan** designed for persons living in Europe, where all **benefits** and **premiums** are payable in euro.

Resident Health Plan - A **plan** designed for persons living in Europe. **Premiums** and **benefits** are payable in euro. Unlike Interplan Euro this is not an age-at-entry **plan** and, therefore, **premiums** increase every **year** because of both age and the main factors influencing **premium** rates. This **plan** includes a compulsory **excess**.

Interplan Worldwide - A **plan** designed for persons predominantly resident outside Europe.

Our **Policy Review Team** will be happy to talk you through these options. **We** recognise that in re-assessing your insurance needs you may wish to consider the range of plans available across the private medical insurance market as well as the **Society**. If so, **we** recommend that you consult the intermediary who arranged your **policy**, if applicable. Alternatively, if you purchased your **policy** direct from the **Society**, **we** are able to provide you with a list of intermediaries specialising in medical insurance who would be able to assist you with this.

Important Notes For New *Policyholders*

Please bear in mind that utmost good faith is a very important principle in insurance. **Your** signed and dated application form is an integral part of **your policy** and the cover **we** provide. If it contains materially incorrect or incomplete facts **we** have the right to refuse payment of a claim or cancel your cover.

You should therefore have taken the greatest care to ensure that you completed the application form fully and accurately, and that you did not withhold any material facts that may affect the terms of acceptance.

Please Note - if any changes occur, or have occurred, in the facts given by you between the date on which you completed your application form and the date your **policy** becomes effective, you must inform the **Society** immediately.

Please check carefully all the documents sent to **you** by the **Society** to ensure that they meet your requirements. Your **policy** will not be activated until **we** receive confirmation of your acceptance of the **policy** terms. If you are not entirely satisfied with the terms of your **policy** with the **Society** and the extent of the **benefits** provided, **you** may cancel your cover.

We will cancel your **policy** if you advise **us** that **you** wish to cancel the cover not later than 14 days after **we** confirm your cover to you, or 14 days after the commencement date of the **policy** if later.

We will refund **premium** payments made under the **policy** less a sum representing a fair **premium** for the period for which the **policy** was on risk, calculated on a pro rata basis.

Age At Entry Pricing Explained

Introduction

Many of the **Society's** products are priced on an "Age at Entry" basis; "The age you join is the age you stay". The purpose of this section is to explain:

- what this approach means for you in practice
- the assurances that are being offered
- what is guaranteed and what is not.

Brief summary

Put simply, the **Society's** approach means that your **premium** will not increase solely because you (as an individual) get older, provided that your cover remains unchanged. Your **premium** is determined by the age at which you joined the **Society**, rather than your age at each renewal (see "Dependent Children" on page 11 for an explanation of how this is applied to any children included on your **policy**).

It does not mean that your **premium** will not increase at all. Indeed the expectation is that your **premium** is likely to increase **year-on-year** because of a variety of factors (see "Factors influencing **premium** rates" below) and generally at a rate greater than retail price inflation. However, the **Society's** policy means that your **premium** should rise more gradually as you get older because it will only move in line with the increases required to keep the **plan** as a whole on a sound financial footing and not because your age increases.

In general the cost of Private Medical Insurance increases significantly with age and with most insurers your **premium** would rise more rapidly as you got older.

What is guaranteed?

The **Society** guarantees that your **premium** in any future **year** will always be calculated with reference to the age at which you joined the **Society**, for as long as you remain a **member** of the same **plan** with the same cover (including any optional **excess**). This means that you will pay a lower **premium** than an otherwise identical **member** on the same **plan** and level of cover, provided you joined at an earlier age.

If your **plan**, **excess** or level of cover is changed, the **Society** may change the age on which your **premium** is based.

What is not guaranteed?

The **Society** does not guarantee the level of **premium** that you will be charged in future **years**. Within the constraints set out in the previous section, the **Society** has complete discretion to alter the **premium** rates for a particular **plan** and level of cover.

The **Society** does not guarantee the level or continuing existence of any discounts that may have been granted in the past.

The **Society** will be guided by the need to ensure its continued financial well-being and to meet statutory levels of solvency. This need will, if necessary, take precedence over the approach outlined in this section.

What if I change my cover?

In general, if the **Society** considers that the extent of your cover is reduced then you will be allowed to remain on your original age at entry (provided that the **plan** to which you are transferring is also age-at-entry). However, if the **Society** considers that the extent of your cover has been increased then you will normally be “re-

age-rated”, i.e. your new **premium** will be calculated with reference to your age at the time of the change. In this context the **Society** may consider any of the following to mean an increase in cover: a change to a **plan**, or level within a **plan**, that offers higher **benefits**, and/or a reduction in the amount, or removal, of an optional **excess**.

This is because the age-at-entry pricing structure that the **Society** operates relies on an element of pre-funding and cross-subsidy; i.e. some of the **premiums** that you and other **members** pay in the early **years** of your **policies** will contribute to a reserve set up to meet claims arising in the later years of those **policies**. However, if you increase your level of cover then the **premiums** that you will have contributed to the reserve will not reflect the expected future claims under your increased level of cover. Therefore, in order to ensure fairness to other **members**, the **Society** “re-age-rates” **members** when the extent of their cover is increased.

Factors influencing **premium** rates

Increases to **premium** rates are applied on each annual **renewal date** of your **policy**. In general the **Society** will aim to ensure that **premiums** for each **plan** and **plan** level are at least sufficient to cover the expected claims and expenses over the long term. From time to time the **Society** may decide that **premiums** need to be lower or higher than this in order to use up or accumulate some of its reserves and to ensure fairness to its members.

The main factors which influence the **premium** increases are:

- the recent incidence of claims within your **plan** and level of cover

- the size (i.e. monetary amount) of those claims
- expected future changes in claim patterns
- changes to the **benefits** covered by your **plan**
- expenses of running the business including Insurance Premium Tax and other government taxes and levies
- investment returns on the **Society's** reserves
- the current level of **premiums** relative to the above factors
- the impact of inflation
- changes in the membership profile within a **plan** or level of cover
- the level of reserves held by the **Society**
- statutory solvency and other requirements.

Friendly society status

Because **we** are a friendly society all surpluses are retained for the benefit of members rather than being paid out to shareholders. This may lead to:

- improved security of **benefits** through the **Society's** increased financial strength
- more generous cover on the **Society's plans**
- **premiums** being held at a lower level than would otherwise have been the case.

However, because **we** have no shareholders the **Society's** only source of capital is its members, so **we** have a duty to ensure that the **Society** remains financially strong at all times in order to

protect members' **benefits**. Therefore the **Society's** continued financial well-being will always be an overriding objective in the setting of **premiums**.

Paying Your Premium

The **policyholder** is responsible for ensuring that **premiums** are paid on time. Sometimes **policyholders** arrange for someone else to pay the **premiums** on their behalf. **We** will only send information about **premiums** and other correspondence about the administration of the **plan** to the **policyholder** and so the **policyholder** must pass this to the person who pays the **premium**. The **policyholder** retains ultimate responsibility for all matters concerning the payment of the **premium**.

Premiums for this **plan** must be paid using one of the following payment methods. Direct Debit payments must be from a **United Kingdom** bank account. Only annual Direct Debit (i.e. by one instalment) attracts a **premium** discount of 5%:

- annually by Direct Debit (5% **premium** discount)
- monthly by Direct Debit
- annually by credit card (Visa or Mastercard only)
- annually by cheque made payable to Exeter Friendly Society.

Please note: **we** do not accept payment by American Express.

Renewing Your *Policy*

Your *policy* with the *Society* will run initially for a *year* from the date on which you first join. This means that you do not have to commit yourself to a long-term contract and you can reconsider your position each *year*.

Equally *we* are not committed to remaining your medical insurer for more than one *year* at a time. However, *we* appreciate that you may wish to have some assurance that you will be able to renew your cover each *year*. You can generally expect to be able to renew *year* after *year* at the *premium* *we* quote for the coming *year* for the *plan* (and the level of *benefits*) to which you currently belong, as long as the *plan* is still being offered. By this *we* mean that *we* will never arbitrarily or unreasonably refuse to renew your *policy*. In rare cases, where *we* decide that a *policy* should not be renewed, *we* will always give you due notice of *our* intention to refuse renewal.

Some reassurance about renewal may also be of value for the following reason: although the *Society* does not normally cover *pre-existing conditions*, if you continue your *policy*, *we* will regard the date on which you joined the *Society* as the date for considering whether or not your condition is looked upon as pre-existing.

Where renewal is offered, *we* will write to you at least 21 days before your *renewal date* confirming the terms of your cover for the coming *year*, including the revised *premium* to be paid. If you have a Direct Debit arrangement in place to pay your *premium*, *we* will continue to apply that arrangement to your *policy*, at the revised rate, unless *we* hear from you to the contrary.

Dependent children

If you include a child on your *policy*, please note that they may continue to be covered until your first *renewal date* on or after their 21st birthday. At this date, they may continue their existing cover by taking out a *policy* in their own right and their *premium* will initially be calculated by reference to the rate applicable to a 21 year-old *policyholder*, and will remain calculated according to that age, unless of course they subsequently break and/or change their cover (see “Age At Entry Pricing Explained” on page 8).

Cancelling Your *Policy*

If you wish to cancel your *policy*, please contact *us*, and *we* will effect the cancellation as soon as is allowed under the rules of your *plan*. If you notify us within 14 days of the commencement of your *year*, *we* will refund any *premiums* already paid for that *year* less an amount of *premium* to cover the period your *policy* was on risk. This is your statutory right to cancel. If you do not exercise this right, *you* can only terminate by not renewing for the next *year*. Cancellations at any other time are allowed at the sole discretion of the *Society*, and any decision will take into account any *premiums* or claims already paid in the current *year*. On no account will the *Society* refund a *premium* that relates to a period prior to the date *we* receive your request to cancel except as allowed upon joining and renewal, or in the event of the death of a *member* (please refer to rule 4.5).

Excesses

If **you** have chosen to take out an **excess** on your **plan**, this will be shown on your **Policy Certificate**. This means that **you** have agreed to waive entitlement to any **benefits** (including Hospital Cash **Benefit**) to which you would otherwise have been entitled, up to the value of the **excess**, for each **member** included on your **policy**. Any **excess** forms part of your claim and is applied against your **benefits** and not the expenses.

We apply any **excess** to each person on the **policy** each **year** if you claim. The **excess** starts again at your **renewal date**, so if you have any **treatment** which spans two **years**, the **excess** will be applied twice, once for each **year**.

Any **benefit** entitlement waived because of an **excess** still counts towards your **benefit** limits as if **we** had paid the **benefit** in full.

When you have **treatment** for an eligible condition that you know will not be covered because of an **excess**, you will still need to send the invoices or a claim for Hospital Cash **Benefit** to **us** so that **we** can take these into account when checking any future claims.

When **we** receive invoices for any **treatment** you have had, or a Hospital Cash **Benefit** claim **we** will:

- check the details to make sure that all the charges made are covered under your **plan**
- apply any **benefit** limits on your **plan** to the invoices or Hospital Cash **Benefit** claim
- deduct the **excess** from any payments due
- write to **you** telling **you** how much **we** have paid, and let **you** know whether or not you need to pay anything to the **specialist** or hospital.

We currently offer **premium** discounts of:

- 5% for a £100 **excess**
- 10% for a £250 **excess**
- 25% for a £500 **excess**
- 30% for a £750 **excess**
- 35% for a £1,000 **excess**.

Occasionally **we** may decide to review either the levels of **excess** offered or the discounts that relate to them. If **we** do this, **we** will let **you** know before your **renewal date**.

Here are some examples of how the **excess** works:

Example 1

Margaret is a **member** of the Preferred Plan with an **excess** of £100. Her **policy** runs from 1 March each **year**. In July, she is referred to a **specialist** and her claim is approved by **us**. The **specialist** charges her £80. This is her first eligible charge in this **year**. As she has an **excess** of £100, she will need to pay this invoice herself, and send the invoice to **us** so that **we** can take this into account when paying any further claims this **year**.

She has two further consultations in August and September, and the **specialist** charges £80 each time. **We** will pay £140 towards the cost of these charges. **We** will then write to Margaret to advise her that she needs to pay the remaining £20, because of the outstanding amount on her **excess**.

In October, Margaret is referred to a **specialist** for a different medical condition, and sends **us** an invoice for a further £80. As the **excess** is applied to each person on the **policy** each **year**, and not to each medical condition, **we** will pay this invoice in full.

Example 2

Steven is a **member** of the Preferred Plan with an **excess** of £250. His **policy** runs from 1 September each **year**. On 30 August, he is admitted to hospital for surgery. He has already paid £160 of his **excess** for the **year** for previous eligible charges. He is discharged on 2 September so his **treatment** spans two **years**.

The hospital sends **us** an invoice for £2,400. **We** then deduct £90 from the amount payable to cover the remaining **excess** for the first **year**. However, **we** will then deduct a further £250 in order to cover the **excess** for the second **year**. **We** will therefore pay £2,060 to the hospital and Steven will need to pay the outstanding amount of £340.

	Year 1	Year 2
	£	£
Excess	250.00	250.00
Already paid	160.00	-
Excess still to pay	<u>90.00</u>	<u>250.00</u>
Total of invoice for <i>treatment</i> 30 August - 2 September		£2,400.00
Remaining excess payable by Steven (Year 1)		£90.00
Excess payable by Steven (Year 2)		£250.00
Total excess payable by Steven		(£340.00)
Remaining amount payable by <i>us</i>		<u>£2,060.00</u>

Example 3

Mary is a **member** of the Preferred Plan with an **excess** of £250. Her **renewal date** is 1 June. In January, she injures her ankle and is referred to a physiotherapist. She has ten sessions of physiotherapy at a cost of £40 per session, and sends the invoices to **us**.

Initially, **we** apply the **benefit** limits of her **plan**, which allows up to £300 per **year** for physiotherapy. This means that only £300 of the £400 **treatment** costs are eligible for **benefit**. However, as Mary also has an **excess** of £250 on her **policy**, **we** will then deduct this from the £300 allowable, so **we** will only be liable for £50 of the costs. Mary will therefore need to pay £350 of the costs herself.

The following shows what would have been payable had no excess been chosen, together with the amount payable with the excess.

	No Excess	£250 Excess
	£	£
Total of Invoices	400.00	400.00
Benefit available	300.00	300.00
Excess deductible	0.00	250.00
Amount payable by us	<u>300.00</u>	<u>50.00</u>
Amount payable by Mary	<u>100.00</u>	<u>350.00</u>

Example 4

Catherine has taken out the Low Cost Plan with an **excess** of £750, and has included her daughter on her **policy**. The **policy** runs from 17 September. In October, her daughter is admitted to hospital and her **treatment** costs £1,500. **We** will deduct £750 from this to cover the **excess**, and will pay the remaining £750.

In March, Catherine is also admitted to hospital and the **treatment** costs £2,600. Because the **excess** is applied to each person on the **policy** each **year** if an eligible claim is submitted, **we** will deduct Catherine's **excess** of £750 and pay the remaining £1,850.

Example 5

David is on the Low Cost Plan with an **excess** of £500. He sends **us** an invoice for **out-patient diagnostic tests** totalling £900. The maximum **benefit** claimable by David for **out-patient diagnostic tests** is £300, therefore this is the maximum amount he can offset against his **excess** for the current **year** and the full £900 is payable by David. He has also used all his **out-patient benefit** until his next **renewal date**.

The following shows what would have been payable had no excess been chosen, together with the amount payable with the excess.

	No Excess	£500 Excess
	£	£
Total of Invoices	900.00	900.00
Benefit available	300.00	300.00
Excess deductible	0.00	300.00
Amount payable by us	<u>300.00</u>	<u>0.00</u>
Amount payable by David	<u>600.00</u>	<u>900.00</u>

Any further invoices received are still subject to the remaining **excess** amount of £200 being deducted from the amounts claimable for the **year**. He has also used all his **out-patient benefit** until his next **renewal date**.

Increasing or reducing your level of **excess**

You can only increase or reduce your level of **excess** with effect from your **renewal date**. If **you** increase your level of **excess**, **we** will apply your new higher **excess** to any claims you make after your **renewal date**.

If **you** reduce your level of **excess**, any claims for new conditions made after this change will have the new lower **excess** level applied. However, any medical conditions which began before your **renewal date** will have the old higher **excess** level applied to them.

Here are some examples of how this works:

Example 1

Sarah has an **excess** of £250. Her **renewal date** is 1 June, and after a **year** of having the **policy** she decides to increase this **excess** to £500. In September, she makes a claim. **We** will apply her new **excess** of £500.

Example 2

Tom has an **excess** of £1,000. His **renewal date** is 15 August and he decides to reduce his level of **excess** to £500. In December he begins to get pain in his hip and is referred to a **specialist**. He has not had any previous problems with his hip. **We** will therefore apply his new **excess** of £500, as this is a new condition.

Example 3

Sheila has an **excess** of £750. Her **renewal date** is 1 February, and she decides to reduce her **excess** to £500. In January, she went to see her **primary care physician** about a medical condition and he referred her to a **specialist**.

She sees the **specialist** on 3 February and is later admitted to hospital for **treatment**. **We** will therefore apply the original **excess** of £750, because the condition started before she changed to the new **excess** level.

Your *Hospital Choice List*

Your *Hospital Choice List* shows the wide range of hospitals providing medical facilities that are available to you. All hospitals on the list are classified as either Level 1 or Level 2. **We** class the hospitals by their level of charges and not by where they are in the country. NHS hospitals on the list are denoted by an asterisk. Not all of the NHS hospitals listed have designated facilities for private patients.

Please take this list with you when visiting a *specialist*, so that you can arrange to use a hospital covered by your *plan* if *in-patient treatment* or *day-patient treatment* is required.

Level 1 Cover

If you have Level 1 Cover, you will be covered for eligible *in-patient treatment* or *day-patient treatment* in any of the hospitals included on the list. However, you will not be covered for any of the costs associated with *in-patient treatment* or *day-patient treatment* in a hospital not on the list, or in a hospital outside the *United Kingdom*.

Level 2 Cover

If you have Level 2 Cover, you will be covered for eligible *in-patient treatment* or *day-patient treatment* in a hospital classified as Level 2. However, you will not be covered for any of the costs associated with *in-patient treatment* or *day-patient treatment* in a hospital classified as Level 1, or not included on the *Hospital Choice List* or in a hospital outside the *United Kingdom*.

Most *specialists* have admitting rights to more than one hospital, and will be able to refer you to a hospital within your level of cover. However, occasionally, a *specialist* may wish to refer you to a hospital that is not covered under the terms of your *plan*. In certain circumstances, the *Society* may be able to negotiate for your admission so that you may have *treatment* at that hospital. If **we** are able to negotiate for you, there is a £100 administration fee payable to the *Society* by you. If this is not possible, it may be necessary for you to change *specialist* in order to be admitted to a hospital within your level of cover. If this happens, *benefits* will be available in respect of the charges made by both *specialists* according to the terms and *benefit* levels of your *plan*.

Please note that in rare cases, certain specialised procedures may involve travelling further afield than your local hospital within your level of cover. You are advised to check that the *specialist* you choose will be able to carry out the required procedure at the hospital of your choice.

If you are in any doubt about whether or not you will be covered, please contact **Customer Support** on 0300 123 3200 before you go ahead with any *treatment*.

A Guide To Making A Claim

When a *primary care physician* wants *you* or any of the other persons on *your policy* (hereinafter referred to as the “patient”), to see a *specialist* or have some tests, and *you* intend to apply for *benefit* from the *Society*, there are a few things *you* must do before the patient visits the *specialist* or has any tests.

New medical conditions

Contact **us**. Please telephone **Customer Support** on 0300 123 3200 as soon as possible. **You** and/or the patient (if not **you**) will be asked some questions about the medical condition requiring referral and the **specialist** to whom the patient is being referred. From the responses provided, **we** will usually be able to confirm immediately whether or not **benefit** may be available. If so, **we** will issue a form for the patient to take along to the **specialist**, which requests further information about the medical condition and, where applicable, the proposed **treatment**. By signing this form the patient will be authorising that the **specialist** may release to the **Society** a copy of the **primary care physician's** referral letter to the **specialist**. If the patient does not consent **we** reserve the right to refuse the claim. Any claim for **benefit** received within the first **year** of being a **member** is automatically referred to **our** Chief Medical Officer for assessment.

Ongoing medical conditions

If you need a further consultation / **treatment** for a condition that has already been approved and registered with the **Society**, please contact **us** and let **us** know what **treatment** is proposed, the **specialist's** name and, if appropriate, the admitting hospital. **We** will then check that your proposed **treatment** is in accordance with your chosen **plan** and level of cover and that you have the **benefits** available to enable **us** to assess and settle any invoices **we** receive for your **treatment**.

When the patient visits the **specialist** **we** strongly recommend that he takes along this Policy Document and the **Hospital Choice List**, as the **specialist** may need to refer to these in order to establish if the proposed **treatment** and/or choice

of hospital are covered by the **benefits** available. In certain circumstances, **we** may need to contact, or obtain reports from, others involved in the patient's **treatment** and, if so, **we** will need separate consent from the patient for this.

Oncology Support Team

If you are a **cancer** patient and you are to have, for example, chemotherapy or radiotherapy, telephone **our Oncology Support Team** on 0300 123 3200 who are there to help you.

We have established this team to make **our** involvement in your **oncology** care as simple as possible. **Our** aim is to provide a service to **our members**, which will help you by being co-operative and caring. Experienced staff will communicate with you throughout the management of your claims, to smooth any concerns you may have about the financial aspects of your **treatment**. Integrity and confidentiality will be displayed at all times during your treatment plan; **we** will act in the utmost good faith to offer an efficient service.

Arranging your **treatment**

Once the fully completed form and copy of the **primary care physician's** referral letter have been returned to **us**, **we** will assess whether the proposed **treatment** is eligible for **benefit** and, if approved, the patient may proceed with the **treatment**. If, as the **treatment** progresses, you have any queries about the claim or the extent of the **benefits** available to cover the costs incurred, please telephone **Customer Support** on 0300 123 3200 for advice.

Exeter Care Preferred and Low Cost Plan Table

This table shows the **benefits** which apply to each person covered under these **plans** each **year**. Please refer to the chosen hospital level and the particular terms of your own **policy**. There is NO OVERALL ANNUAL MAXIMUM.

<i>In-Patient and Day-Patient Benefits</i>	Preferred	Low Cost
Hospital Charges	Paid in Full	Paid in Full
<i>Specialist Services</i>	Paid in Full	Paid in Full
<i>Pre-Admission Tests</i>	Paid in Full	Paid in Full
<i>Out-Patient Benefits</i>	Preferred	Low Cost
<i>Specialist</i> Consultations (Preferred Plan)	£750 per year	-
<i>Diagnostic Tests</i> (Preferred Plan)	£2,000 per year	-
<i>Specialist</i> Consultations and <i>Diagnostic Tests</i> (Low Cost Plan)	-	£300 per year
Manipulative Treatment (physiotherapy, osteopathy, chiropractic)	£300 per year	-
Other Health Care Professionals (podiatry/chiroprody, speech therapy, occupational therapy, dietician, acupuncture, homeopathy, pain clinics)	£100 per year	-
<i>Out-Patient Surgery</i>	Paid in Full	Paid in Full
<i>Additional Benefits</i>	Preferred	Low Cost
<i>Oncology</i>	£27,500 per year	£16,500 per year
GP Helpline	Unlimited 24/7 Access	
<i>Home Nursing</i>	£25 per day up to 30 days per year	-
Private Ambulance	£200 per year	-
Hospital Cash <i>Benefit</i>	£100 per day up to a maximum of £2,000 per year	£100 per day up to a maximum of £2,000 per year
<i>Hospice</i> Donation	£250 per year	£250 per year

Important Note: The payment of all **benefits**, including when expressed as paid in full, must be eligible and not **customary** for the **treatment** received.

e of *Benefits*

Remember that your being able to claim these *benefits* will depend on *our* rules, the limits within the MUM to the total *benefits* payable to each *member* in any one *year*.

Notes

Includes *accommodation*, nursing, theatre fees and consumables, surgical drugs and dressings, *diagnostic tests*, scans, physiotherapy, pathology and eligible *prostheses* for *in-patient treatment* and *day-patient treatment* at a hospital within your chosen level, selected from the current *Hospital Choice List*. (Please note that drugs or dressings to take home with you are not covered, see Rule 8(l).)

Surgeon's, anaesthetist's and physician's fees for *in-patient treatment* or *day-patient treatment* at a hospital within your chosen level, selected from the current *Hospital Choice List*.

These will be included as part of your *in-patient/day-patient* hospital charges providing they are carried out at the admitting hospital and within the two weeks prior to your admission. These are limited to pre-operative blood tests, electrocardiograms (ECGs) and a chest x-ray.

Notes

Available for *specialist* consultations, including follow-ups.

Available for procedures such as x-rays, ECGs, pathological tests, CT, PET and MRI scans. These entitlements include professional fees where appropriate.

Available for *specialist* consultations, including follow-ups and *diagnostic tests*.

Treatment may be undertaken only following referral by your *primary care physician* and administered by a practitioner whose name appears on the appropriate register.

A surgical procedure when performed by a *specialist* in a consulting room or at a hospital on the *Society's Hospital Choice List* or any NHS hospital.

Notes

Includes radiotherapy and chemotherapy under the management of an oncologist at a hospital within your chosen level (to include monitoring required during each fraction or cycle of *treatment*). Subject to the stated annual limit. *Cancer* surgery is paid out of the *In-Patient and Day-Patient Benefits*.

See page 29 for further information and access details

Payable for medical as opposed to domestic reasons and must be undertaken under the supervision of the attending *specialist*.

Payable towards the cost of a private road ambulance to, from or between hospitals. The use of the ambulance must be medically essential and required in connection with eligible *in-patient treatment* or *day-patient treatment*.

Paid when the patient is admitted as an *in-patient* to a *UK* NHS hospital bed for eligible *treatment* which would be paid for under your private medical insurance and no fees for *treatment* are incurred. (This *benefit* cannot be claimed for an *emergency admission* and is still subject to any *excess* deduction, where applicable.)

Paid as a donation to the *hospice* (irrespective of length of stay) if the patient requires admission for care.

necessarily incurred and will be paid in accordance with those fees deemed by the *Society* to be *reasonable and*

Payment of invoices

We are able to settle invoices directly with most hospitals and **specialists**. They can forward invoices directly to **us**, and **we** will deal with them for you, saving you time and expense.

If you wish **us** to settle invoices directly for you, please tell the hospital and/or **specialist** your **policy** number and claim number. This will help **us** to avoid delays in settling the invoices.

When **we** have settled an invoice for you, **we** will write to **you** and confirm how much **we** have paid. **We** will also advise **you** if you need to pay for any of the **treatment** because it is not eligible under your **plan**, or because you have an **excess** on your **policy**, or because you have reached a **benefit** maximum.

If you do have to settle an invoice yourself and wish **us** to reimburse **you**, **we** will require the original, itemised invoice, together with **your** request for reimbursement quoting your **policy** number and claim number. Wherever possible **we** will reimburse **you** by direct credit transfer to the bank account from which **we** collect your **premiums**.

We strongly recommend you to check the invoices you receive and inform the provider or **us** of any discrepancies.

Please note: **we** are unable to accept photocopied or e-mailed invoices.

Treatment Costs

Procedure Code	Operation Description	Approx Total Cost	Avg Length of Stay
M4510	Bladder - diagnostic endoscopic examination of bladder	£1,200	<i>Day-Patient</i>
H3330	Bowel - removal of part of the bowel - anterior resection	£15,000	10 Nights
H2002	Colon - colonoscopy - diagnostic examination	£1,860	<i>Day-Patient</i>
C7122	Eye - Cataract removal	£2,595	<i>Day-Patient</i>
J1830	Gall bladder removal - laparoscopic cholecystectomy	£4,800	1 Night
K4910	Heart - Angioplasty with stent	£11,900	1 Night
K2600	Heart - Aortic valve replacement	£25,700	10 Nights
K6510	Heart - Cardiac catheterisation - adult	£2,250	<i>Day-Patient / 1 Night</i>
K6010	Heart - Cardiac pacemaker system	£11,130	1 Night
K4100	Heart - Coronary artery bypass graft	£25,850	8 Nights
T2000	Hernia - inguinal - primary repair	£1,820	1 Night
W3732	Hip - replacement of 1st hip replacement (revision)	£15,800	9 Nights
W3712	Hip - 1st total hip replacement	£11,000	5 Nights
W3715	Hip resurfacing - metal on metal procedure	£10,700	7 Nights
W8500	Knee - arthroscopic operations on knee cavity	£3,050	<i>Day-Patient</i>
W8200	Knee - removal of cartilage in the knee - arthroscopic meniscectomy	£2,910	<i>Day-Patient</i>
W4210	Knee joint - total prosthetic replacement	£11,400	7 Nights
H0610	Large intestine - extended excision of right hemicolon	£9,000	8 Nights
M6530	Prostate - removal of the prostate gland - resection of prostate (TURP)	£4,600	3 Nights
G6500	Stomach - gastroscopy - diagnostic examination	£1,230	<i>Day-Patient</i>

- Above figures are based on 'average costs' across various **UK** hospitals.
- Actual prices may be affected by age, health, length of stay, location of hospital/**specialist** and other factors and based on data available as at October 2008.
- The **benefits** payable against the costs of these procedures will depend on the terms of your **policy** and so should not be relied upon as an indication of your **benefit** entitlement.

Chronic Conditions

Introduction

The following information is designed to explain what a **chronic condition** is, and how **we** would deal with any claims you make for a condition which **we** consider to be chronic.

Q. What is a **chronic condition**?

A. A **chronic condition** is a disease, illness or injury that has at least one of the following characteristics:

- it continues indefinitely and has no known cure
- it comes back or is likely to come back
- it is permanent
- you need to be rehabilitated or specially trained to cope with it
- it needs long-term monitoring, consultations, check-ups, examinations or tests.

We will not cover **chronic conditions** following the initial diagnosis and therapy. Please note, however, that **we** do not consider **cancer** to be a **chronic condition**.

Q. What does this mean in practice?

A. When you are referred to a **specialist** by your **primary care physician**, **we** will request some information about the condition for which you wish to claim **benefits**. **We** will check this (and any supporting information) to make sure that **we** can cover your claim.

If **we** consider the condition for which you need **treatment** to be chronic, **we** will only cover the initial investigations leading to a confirmed diagnosis, and

the initial **treatment** needed to stabilise the condition (providing the **treatment** is covered under your **plan**).

We will not pay for any **treatment** once the diagnosis has been made and the condition has been stabilised.

Q. What if your condition gets worse?

A. In some cases, **we** will pay for further **treatment** if your condition gets worse. **We** may pay for **treatment** relating to an acute episode of a **chronic condition**.

For example, **we** consider asthma to be a **chronic condition** and do not pay for any ongoing **treatment** or monitoring. However, an asthma attack would be classed as an acute episode.

Under the terms of this **plan**, **treatment** within 5 **days** of an **emergency admission** is not covered. However, if there is no **emergency admission** or if further **treatment** is needed following the 5 **days** in order to stabilise the condition, **we** may consider paying for this providing that particular **treatment** is covered under the **plan** and there is **benefit** available. In order to consider this **we** usually request a medical report or ask for additional information.

Examples of Chronic Conditions

Example 1 - Angina and heart disease

Alan has been with the Exeter Friendly Society for many **years**. He develops chest pain and is referred by his GP to a **specialist**. He has a number of investigations and is diagnosed as suffering from angina. Alan is placed on medication to control his symptoms.

We do not consider angina to be a **chronic condition**. This means that as long as Alan's claim has been approved by **us**, and the investigations are covered under

the **benefit** limits of the **plan**, we will pay **benefits** for these investigations. We will not, however, pay for the medication.

Two years later, Alan's chest pain recurs more severely and his **specialist** recommends that he has a heart by-pass operation.

We will pay for the operation and any follow-ups needed, as long as **benefits** are available for these under the terms of Alan's particular level of cover.

Example 2 - Asthma

Eve has been with the Exeter Friendly Society for five **years** when she develops breathing difficulties. Her GP refers her to a **specialist** who arranges for a number of tests. These reveal that Eve has asthma. Her **specialist** puts her on medication and recommends a follow-up consultation in three months to see if her condition has improved. At that consultation Eve states her breathing has been much better. So the **specialist** suggests she has check-ups every four months.

Providing the claim is approved by **us**, we will pay for the initial consultation and tests, up to the **benefit** limits of the **plan**. Once the condition has been stabilised, we will not pay for the check-ups.

Eighteen months later, Eve has a bad asthma attack.

We may consider this to be an acute episode. Under the terms of this **plan**, **treatment** within 5 **days** of an **emergency admission** is not covered. However, if Eve does not undergo any **emergency admission** and needs **treatment** to stabilise her condition, or if she needs further **treatment** after an **emergency admission**, we would consider paying for further **treatment** for this providing **benefits** are

available under her chosen **plan**. We would usually request a medical report or ask for additional information in order to consider this.

Example 3 - Diabetes

Deidre has been with the Exeter Friendly Society for two **years** when she develops symptoms that indicate she may have diabetes. Her GP refers her to an endocrinology **specialist** who organises a series of investigations to confirm the diagnosis, and then she starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments to the medication regime, the **specialist** confirms that the condition is now well controlled and explains that he would like to see her every four months to review the condition.

We consider diabetes to be a **chronic condition**. Providing the claim is approved by **us**, we will pay for the initial consultation and investigations, up to the **benefit** limits of the **plan**. We will pay for follow-up consultations until the condition has been stabilised providing Deidre has not reached her **benefit** limit. However, we will not pay for the medication prescribed.

One **year** later, Deidre's diabetes becomes unstable and her GP arranges for her to go into hospital for **treatment**.

We may consider this to be an acute episode. Under the terms of this **plan**, **treatment** within 5 **days** of an **emergency admission** is not covered. However, if Deidre's admission to hospital was not an **emergency admission** or if she needs further **treatment** to stabilise her condition

outside the 5 **days**, **we** would consider paying up to the eligible **benefit** limits. **We** would usually request a medical report or ask for additional information in order to consider this.

Example 4 - Hip pain

Bob has been with the Exeter Friendly Society for three **years** when he develops hip pain. His GP refers him to an osteopath who treats him every other day for two weeks and then recommends that he return once a month for additional **treatment** to prevent a recurrence of his original symptoms.

Once **we** have approved the claim, **we** will pay for the cost of the osteopathy **treatment** providing Bob has **benefit** for osteopathy under his chosen **plan** and he has not reached his **benefit** limit.

An Explanation of **Cancer** Cover

This section will explain the cover available to you for **cancer**, and how and under which **benefit** each item is assessed.

There are no time limits on the cover for **cancer**. However, there are **benefit** limits which may apply, as indicated, and therefore the following details must be read in conjunction with the Table of **Benefits** for your chosen **plan**, in particular the **out-patient** and **oncology benefit** limits.

You are not covered for any conditions for which you have specific exclusions on your **policy**, nor for the recurrence of any such exclusions.

The following table is a summary of what is and isn't covered for **cancer** and the second table overleaf shows from which **benefit** each category of **treatment** is paid.

A summary of **Cancer** Care

Please note that the **chronic condition** rule does not apply to **cancer** claims and **benefit** is available for medical expenses that are eligible, **reasonable**, and **customary** and subject to the **benefits** available under your chosen **plan**.

	Cover	
Place of Treatment	✓	Hospital or clinic as an in-patient , day-patient or out-patient , or at home
Diagnostic	✓	Consultations with specialist , diagnostic tests and scans to enable a diagnosis to be made, subject to the out-patient benefit limits
Surgery	✓	Received prior to the start of an oncology Treatment regime, subject to the in-patient or day-patient benefit limits
Drug Therapy	✓	Chemotherapy - intravenous or oral and associated medication (e.g. anti-sickness drugs) Biological therapy This is paid from the Oncology benefit
	✗	You are not covered for drugs which are given to maintain remission as these are usually prescribed by a GP
Radiotherapy	✓	Sessions of radiotherapy including when given for pain relief and is paid from the Oncology benefit
Palliative care	✓	If recommended by the Oncologist for the control of the cancer and paid from the Oncology benefit
Monitoring	✓	For the first 3 months after completion of the treatment regime - follow up consultations, blood tests and scans – paid from the Oncology benefit Further follow up consultations and tests after the above 3 month period – paid from normal benefits
NHS Treatment	✓	If you are treated as an NHS in-patient , you may be entitled to a daily cash benefit , depending on your chosen plan
Treatment outside the UK	✓	Providing pre-authorized by the Society before the treatment commences
Hospice	✗	Donation only according to the available benefit on your policy
Preventative	✗	You are not covered for preventative treatment , screening procedures and tests, including those because of a poor personal or family history, or surveillance investigations, such as a colonoscopy, or vaccinations and immunisations.
Experimental / unproven treatment	✗	You are not covered for any experimental or unproven treatment such as stem cell treatment
Clinical trials	✗	We are very supportive of clinical trials, and your policy remains fully valid throughout the trial. However, the experimental treatment and any complications arising from it remain the responsibility of the research team and are not covered under your policy .
Terminal care	✗	Where the treatment is no longer primarily for the control of the cancer , but the focus is to improve the quality of life for the patient who is approaching the end of their life – for example in a hospice

Here are some examples of how the **cancer** cover works.

Example 1

Carole develops a lump in her left breast which is diagnosed as breast **cancer**. Her **specialist** recommends that she has a mastectomy (breast removal) followed by a course of chemotherapy and radiotherapy.

Providing this is a new condition, and the claim has been approved by **us, we** will pay for the initial consultation and **diagnostic tests**, from her **out-patient benefits** of £750 and £2,000 on the Preferred Plan and £300 on the Low Cost Plan, the operation, from her **In-Patient** and **Day-Patient benefit**, which is paid in full on both **plans** and her chemotherapy and radiotherapy, up to the **benefit** limits of either £27,500 on the Preferred Plan or £16,500 on the Low Cost Plan.

Once Carole's course of **treatment** has been completed, her **specialist** recommends that she has regular check-ups to ensure that she remains free from a recurrence of the disease.

Providing Carole still has **out-patient benefit** available under her chosen level of cover, **we** will pay for these check-ups.

Example 2

Beverly has been with the Exeter Friendly Society for five **years** when she is diagnosed with breast **cancer**. Following discussion with her **specialist** she decides to have the breast removed followed by breast reconstruction. Her specialist also recommends a course of radiotherapy and chemotherapy. In addition she is to have hormone therapy tablets for several years.

Will her insurance cover this **treatment** plan and are there any limits to the cover?

Once the claim has been approved by **us, we** will pay for the consultations, operation and breast reconstruction up to the **benefit** limits of her chosen **plan**. **We** will also pay for the radiotherapy and chemotherapy up to the **benefit** limits of either £27,500 on the Preferred Plan or £16,500 on the Low Cost Plan. Any drugs including Hormone tablets prescribed by her GP will not be covered.

Example 3

Cara has previously had a breast **cancer** which was previously treated by lumpectomy, radiotherapy and chemotherapy under her existing **policy**. She now has a recurrence in her other breast and has decided to have a mastectomy, radiotherapy and chemotherapy.

Will her insurance cover this and are there any limits to the cover?

As this is a new condition, once the claim has been approved by **us, we** will pay for the consultations and operation up to the **benefit** limits of her chosen **plan**. **We** will also pay for the radiotherapy and chemotherapy up to the **benefit** limits of either £27,500 on the Preferred Plan or £16,500 on the Low Cost Plan.

Example 4

Monica, who was previously treated for breast **cancer** under her existing **policy**, has a recurrence which has unfortunately spread to other parts of the body. Her **specialist** has recommended the following **treatment** plan:

- A course of six cycles of chemotherapy aimed at destroying **cancer** cells to be given over the next six months.
- Monthly infusions of a drug to help protect the bones against pain and fracture. This infusion is to be given for as long as it is working.
- Weekly infusions of a drug to suppress the growth of the **cancer**. These infusions are to be given for as long as they are working (hopefully years).

Will her insurance cover this **treatment** plan and are there any limits to the cover?

The whole of the recommended **treatment** plan is eligible but payable under the **Oncology Benefit** and therefore subject to the £27,500 and £16,500 **benefit** limits.

Example 5

Sharon would like to be admitted to a **hospice** for care aimed solely at relieving symptoms.

Will her insurance cover this and are there any limits to the cover?

We do not pay for any admissions to a **hospice**. **We** will, however, make a £250 **Hospice** Donation if a **member** is admitted for care.

Cancer care, how it is assessed and the **benefit** it is paid from

GP Referral	⇒	NO BENEFIT
Consultations with Specialist	⇒	NORMAL OUT-PATIENT BENEFITS - see the Table of Benefits on pages 18 and 19 for the amount available under your chosen plan
Diagnostic tests / scans, e.g. CT, MRI, PET		
In-Patient, Day-patient or Out-patient surgery	⇒	NORMAL BENEFITS
Consultation with Oncologist	⇒	ONCOLOGY BENEFITS - see the Table of Benefits on pages 18 and 19 for the amount available under your chosen plan
Blood tests, scans etc for radiotherapy, chemotherapy or biological therapy regime planning		
Chemotherapy, radiotherapy or biological therapy regime		
Ongoing consultations, blood tests, scans, anti-sickness drugs during treatment regime		
All hospital charges including accommodation during treatment regime		
1st consultation, blood tests, scans etc after completion of regime		
Medical admissions to hospital due to reaction to oncology regime or for blood transfusions	⇒	NORMAL BENEFITS Emergency admission exclusion does not apply
Follow-up consultations, blood tests and scans for the first 3 months after completion of treatment regime	⇒	ONCOLOGY BENEFITS see the Table of Benefits on pages 18 and 19 for the amount available under your chosen plan
Further follow-up consultations and tests after the above 3 month period	⇒	NORMAL OUT-PATIENT BENEFITS see the Table of Benefits on pages 18 and 19 for the amount available under your chosen plan

GP Helpline:

0118 936 5655

Your **policy** with the **Society** gives you access to a confidential General Practitioner (GP) Helpline, which is open 24 hours a day, 7 days a week. This helpline is provided by an independent company selected by Exeter Friendly Society. You can take advantage of this service at any time, so you do not need to wait until you need to make a claim.

You can use this helpline if you need more detailed information about your symptoms, or for more information about a diagnosis or **treatment**.

Dedicated operators will take any information needed and then arrange a convenient time for a private GP to return your call. You will only be charged for the initial call to the helpline operator.

Our Standards

We aim to provide you with access to **plans** that are affordable, and provide for your future wellbeing.

We always act with the highest ethical standards of conduct and professional integrity whilst striving to meet, and exceed, members' expectations.

We try to achieve the following service standards:

- to respond to **your** application for a **policy**, or to amend cover, within five working days
- to process properly presented, eligible invoices for **benefit** within ten working days

- to respond to your correspondence and any other **policy** queries within five working days.

If You Are Not Satisfied

The **Society** provides medical insurance for over 40,000 members. **We** receive a large number of enquiries, together with many claims and requests for information. **We** do **our** best to ensure that these are dealt with quickly and efficiently. However, **we** welcome any new ideas or suggestions that you believe would improve the products provided, the level of service or the standards of management.

Making a complaint

Although **we** are committed to providing you with the highest level of service, **we** do not always get it right. If you are not satisfied with any aspect of the service **we** provide, or the efficiency of **our** response, please refer the matter to **Customer Support** on 0300 123 3200, who should be able to resolve it to your satisfaction.

However, if they are unable to do so, they will refer the matter to the appropriate manager and/or director. If the problem cannot be resolved immediately, **we** will advise you within two working days, telling you how long **our** investigations are likely to take.

If you are still not satisfied with the outcome, **we** will refer your complaint to **our** Quality Controller, who will investigate your complaint separately. You will receive a further response within two working days of receipt of the complaint by the Quality Controller. **We** will provide a full response to your complaint within the following two weeks, provided **we** have received all the information **we** require from any third parties involved.

If you are still not satisfied

If you feel that your complaint has not been resolved by the end of eight weeks from our receipt of your complaint (or if **we** have failed to issue an explanation for the delay in dealing with your complaint by the end of four weeks), you can refer the matter to the Financial Ombudsman Service. Full details will be provided by the Quality Controller with the **Society's** final response.

The existence of the Financial Ombudsman Service does not prejudice your right to take legal action in the event of a dispute. Further information about your statutory rights may be obtained from a solicitor or the Citizens Advice Bureau.

We treat complaints very seriously, and all complaints are recorded and monitored regularly by the Board of Directors. **We** believe that this enables the **Society** to improve and enhance services on a continuous basis.

Financial Services Compensation Scheme (FSCS)

Exeter Friendly Society is covered by the FSCS, which was established under the Financial Services and Markets Act 2000.

This means that you may be entitled to compensation if the **Society** becomes insolvent and is unable to meet its obligations. Insurance advising and arranging is covered in full for the first £2,000 of any claim plus 90% of the remainder without any upper limit.

Further details are available from the FSCS at www.fscs.org.uk or you may telephone them on 020 7892 7300.

Data Protection

We hold information about you in order to provide and administer your **policy** with **us**. Your personal information will be treated in confidence and will only be used by the **Society** for the following purposes:

- The assessment and management of your medical insurance, including contacting you on an annual basis regarding the renewal of your **policy** and processing claims.
- Transmission to those involved in your **treatment** or care.
- Retaining cancelled **policies** and associated details to assist **us** in determining future applications for insurance that you may wish to make.
- Transmission to carefully selected third parties (including the intermediary who arranged your **policy**, if any) as part of **our** administrative operations.
- Transmission to carefully selected third parties for the purpose of research, advertising, marketing or selling (for example to develop and advise you of new products).
- As may be required or permitted by law or as appropriate to detect and prevent fraud and improper claims.

Our purposes for holding, and **our** uses of, personal information, are listed in the Register of Data Controllers. You may inspect this, or obtain a copy of the relevant

entry from the Office of the Information Commissioner (and at its website: www.informationcommissioner.gov.uk).

In order to provide you with insurance **we** will need to process sensitive information (such as medical information) about you and the others named on your **policy**. Please get consent from the people named on your **policy** before sharing their sensitive information with **us**.

At the request of many of **our** members and to make managing your private medical insurance more convenient, **we** may deal with your spouse or partner who telephones **us** on your behalf, if they are included on your **policy**. If you would like someone else to deal with your **policy** on a regular basis, or if at any time you would prefer **us** to deal only with you, please let **us** know.

We have a responsible mailing policy, and may contact you from time to time to inform you of products or services that **we** provide. If you would like to continue to receive this information, you need take no further action. However, if you would prefer not to be part of **our** mailing programme, please write to the Administration Manager at the address shown on the reverse of this document.

Under the terms of the Data Protection Act 1998, you may request a copy of the details **we** hold about you. **We** reserve the right to charge a fee for this service, up to the maximum allowed by the Act. If you require a copy of such information, you should write to the Compliance Director, at the address shown on the reverse of this document.

Policy Rules

1. Policy Terms

1.1 The terms of the **policy** are contained in the following documents, all of which must be read together:

- the Policy Document in force when the **policy** begins, or as amended on renewal
- the table of **benefits** in force when the **policy** begins, or as amended on renewal
- the **Policy Certificate**
- the **Hospital Choice List** in force when the **policy** begins or as amended on renewal
- any application form which you have been required to complete.

In the event of a conflict between any of the documents listed above, the **Policy Rules** in this Policy Document shall prevail.

1.2 None of the **Society's** employees or intermediaries is entitled to make any alteration or amendment to the terms of the **policy** unless it is made in writing and signed by the **Society**.

2. Joining and Renewal

2.1 The **policyholder** is required to complete the correct form to join a **plan**, change their level within a **plan**, change to another **plan** or amend the level of **excess**. The **policyholder** is responsible for ensuring that to the best of their knowledge and belief, the information given to the **Society** about every person included on his application is true, accurate and complete.

2.2 Upon the death of a **policyholder**, a spouse or partner who is registered as a **family member** may without formality become the **policyholder** in his own right.

2.3 Any request for changes to a **policy**, must be made by the **policyholder** on the appropriate form, where applicable, or in writing.

2.4 Any **member** rejoining the **Society** following cancellation will be required to complete a new application form and the **Society** may impose different terms to those previously offered. The **Society** may, at its discretion, allow reinstatement of the **policy** upon receipt of a declaration of health, payment of the outstanding **premiums**, and an administration fee of £100.

2.5 Children born to the **policyholder** after the date of joining may only be added, with proof of their health, at the age of three months or at a later date.

2.6 The **Society** is entitled to refuse to accept any person as a **member** without giving a reason. The **Society** may require a **policyholder** to submit a medical report in respect of any person included in his application, and/or to prove their age.

2.7 The **policy** is for a period of one **year**. If the **plan** is being offered for a further **year** by the **Society** at the **renewal date**, the **policy** may be renewed by the **policyholder** paying the **premium** requested and the **Society** accepting such renewal. By renewing the **policy**, the **policyholder** undertakes to accept the rules and conditions of the **policy** which apply at the **renewal date**.

2.8 The **Society** may place special terms on the **policy** including, but not limited to, the following:

- exclusions of specific medical conditions
- restrictions on particular **benefits** and
- discounts or surcharges on the published **premium** rates.

Any such special terms will be confirmed in writing by the **Society** at the time of joining or renewal.

3. Changes to Cover

3.1 The **policyholder** must write and advise the **Society** immediately if any person included on the **policy** is, or will be, living **overseas** for more than six months of the **year**, so that they may be transferred to a **plan** for **overseas members** (see rule 6.6).

3.2 In normal circumstances, changes from one **plan** to another, a change of level within a **plan** or any change to the level of **excess** can only be effected at the **renewal date**. Changes to cover at any other time during a **year** may be allowed at the sole discretion of the **Society**.

3.3 In the event of a change to a different level of cover and/or **excess**, the **benefits** payable for any eligible medical conditions in existence prior to the change, will be restricted to either the **benefits** available when the medical condition originated or the level applicable at the date of any **treatment**, whichever is lower.

3.4 **Members** may apply to increase their level of cover up to the **renewal date** immediately after their seventy-ninth birthday.

3.5 The **Society** is entitled to refuse a change from one **plan** to another without providing a reason.

3.6 If a **member** changes to a **plan** offering increased **benefits**, increases their level within a **plan** or reduces an **excess**, the **Society** will use the **member's** age at the date of such change to calculate the **premium** payable.

4. Premiums

4.1 The **Society** will determine the amount of **premium** payable at the start of each **year** and will advise the **policyholder**. **Premiums** must be paid to the **Society** for the whole **year** in the manner agreed at that time.

4.2 The **Society** may alter the amount of **premium** payable during a **year** to reflect any change in Insurance Premium Tax or other government taxes or levies, but will inform the **policyholder** at least 6 weeks before the changes become effective.

4.3 **Premiums** are due in advance and must be paid immediately they become due. No **member** in arrears with his **premium** is entitled to make a claim or receive any **benefits**, and the **Society** will cancel any **policy** on which the **premium** is overdue. A **member** may cancel his **policy** within 14 days of receiving his documents or within 14 days after the date the policy starts if later, and a refund of **premiums** paid less an allowance for the period the **policy** has been in force calculated on a pro rata basis. If the **member** or the **Society** cancels a **policy** at any other time, **we** will have the right to retain or demand all or part of the **premium** as a contribution towards any costs the **Society** has incurred.

4.4 In order to comply with money laundering regulations, the **Society** may ask the **policyholder** to provide proof of identity for the payer of the **premium** and for any of the **members** included on the **policy**.

4.5 In the event of the death of a **member**, and providing that the **Society** is notified within six months of the death, the **Society** will make a pro rata refund of the **premium**. This will be calculated by reference to the number of complete months of **premium** already paid which relate to the period after the date of death.

5. Claims

5.1 A **member** proceeds at his own financial risk if he does not contact the **Society** and obtain pre-authorisation prior to the commencement of any **treatment**.

5.2 The **Society** will only consider a claim if:

- a **member** is up-to-date with his **premium** payments
- any outstanding invoices received by the **member** have been submitted to the **Society** within three months of the date of **treatment** and
- the **Society** has been given any additional information (including medical information) requested from the **member** and from any person who has provided or proposes to provide any of the services that are the subject of the claim.

5.3 If a **policy** is subject to an **excess**, claims should be submitted in accordance with rule 5.2 regardless of whether or not the eligible expenses are less than the **excess** amount.

5.4 The **member** must inform the **Society** immediately if any of the expenditure can be claimed, or might be claimed, from anyone else or from any other insurance policy (see rule 6.9).

6. Benefits

6.1 The **Society** will pay those **benefits** entitled to be claimed under the **policy** in accordance with the **Policy** Rules current when the **member** incurred the expenditure (except in circumstances where rule 3.3 applies) and invoices are always assessed according to the rules and **benefits** in force at the date of the **treatment**. Payment can only be made to the service provider or the **policyholder** and not to any other party. If for any reason those **benefits** do not cover the full costs incurred, the **member** will be liable to pay the balance.

6.2 The **Society** will refund only those medical expenses that, in the **Society's** opinion, are **reasonable**, eligible, **customary** and necessarily incurred.

6.3 **Benefits** will be paid in accordance with the **member's** level of cover and, with the exception of Hospital Cash **Benefit** payable for **UK NHS treatment** free of all charges, will not exceed the amount of actual expenditure incurred. **Benefits** cannot be transferred to any other **member** or be carried over to any other **year**.

6.4 The contract for the provision of medical and ancillary services in respect of which **benefits** are paid is between the **member** and the relevant service provider. Notwithstanding that **we** may or do pay on your behalf some or all of the **benefits** directly to the service provider, the **benefits** are intended to indemnify you in respect of all eligible costs of the

treatment in accordance with your **plan**. The primary liability to pay the service provider remains with the **member**.

6.5 If a **policy** is subject to an **excess**, the **excess** applies to each **member** every **year**. Therefore, the **Society** will not pay **benefits** until:

- the **member** has had **treatment** during the **year** which is eligible for **benefits** and
- the amount of the eligible expenses exceeds the **excess** amount.

By 'eligible expenses' **we** mean any expenses that would have qualified for **benefits** had an **excess** not been in place. The amount of any **benefits** claimed for **treatment** that would have been payable but for the **excess** shall nevertheless count towards the **benefit** limits contained within the table of **benefits**. If the **treatment** spans two **years** the **excess** will be applied in each **year**.

6.6 **Treatment overseas** is not covered except with the prior agreement of the **Society**.

6.7 Entitlement to **benefits** will be assessed in pounds sterling. If a claim is made in a different currency, the **Society** will convert the expenditure incurred into sterling, using the exchange rate at which the **Society's** international bankers buy the currency at the time the claim is assessed.

Claim settlements will be paid in pounds sterling. **Members** may request that settlements be paid in a different currency and the **Society** may, at its discretion, agree to provide this additional service. In these circumstances the **Society** will convert the **benefit** entitlement from sterling using the exchange rate at which the **Society's** international bankers sell the currency at the time the claim is paid.

The **Society** will pass on to the **member** any bank charges incurred in handling different currencies together with any other charges made by your bank.

Any shortfall in payments because of exchange rate movements or from the spread between the buying and selling exchange rates will be the **member's** responsibility. Note that the buying rate is always greater than the selling rate and this difference means that if expenses are incurred in a currency other than sterling, they are unlikely to be completely covered by the **benefits** paid, even when all of the expenses are eligible for **benefit**.

6.8 In the event of the death of a **member**, the **Society** may pay any **benefits** due to the following:

- appropriate service providers
- the deceased's personal representatives
- any other person covered by the **policy**, as the **Society**, at its discretion, shall determine.

6.9 The **member** must inform the **Society** if any of the cost can be claimed from anyone else or under another insurance policy. If it can, the **Society** will only pay its proper share.

6.10 Where any **treatment** arises as a result of an injury, or disease for which a third party is, or may be liable, the following provisions shall apply:

- The **member** shall inform the **Society** at the time the claim is made, of the name and address of the third party and whether damages are to be claimed from the third party by the **member** or on his behalf.

- Where the **member** or someone on his behalf is to claim damages from a third party and in consideration of the **Society** agreeing to provide **benefits** under this clause, such person will be required to sign an undertaking; full details to be issued by the **Society** at the time.
- Where the **member** does not intend to pursue a claim for damages against the third party, he shall authorise the **Society** at its own expense to pursue a claim in his name against the third party for the **benefits** paid by the **Society** in respect of such **treatment**, and shall co-operate fully with the **Society** in pursuing such claim including (where necessary) attending court to give evidence as to the circumstances in which the claim against the third party arose.
- Provided the **member** has complied in good faith with the terms of this clause, the **Society** shall only be entitled to recoup from the **member** sums paid in respect of **benefits** so far as such **benefits** are recovered from the third party. Where liability for the incident is apportioned, the **Society** shall be entitled to a pro rata proportion of the **benefits** paid.
- The **member** shall not be entitled to **benefits** save in accordance with the provisions of this clause. Where the **Society's** right to recoup **benefits** from the **member**, or to recover **benefits** paid to the **member** by any third party, has been prejudiced by the **member's** failure to comply with the terms of this clause, the **Society** shall be entitled to recover such **benefits** from the **member** or from the **policyholder**.

By third party **we** mean any person or corporate body other than the **Society** or the person who has received **treatment**.

7. Underwriting Terms

Please note; you will need to refer to your **Policy Certificate** for confirmation as to whether 7.1 (a) or 7.1 (b) applies to the persons covered by your **policy**.

7.1 (a) Where the **member** completed a medical history declaration when applying to join the **Society** (fully underwritten):

Benefits are not payable in respect of any symptoms or medical condition that the **member** already had, or might reasonably have been aware of when the **member** joined; nor for the recurrence of any previous symptoms or medical conditions, unless full particulars were disclosed on the application for the **policy**, or subsequently disclosed and accepted for **benefits** by the **Society**.

7.1 (b) Where the **member** was subject to moratorium terms (i.e. chose not to complete a full medical history declaration) when joining the **Society**:

Benefits are not payable for the investigation or **treatment** of symptoms or a medical condition for which the **member** received advice, medication, tests or **treatment**, or was aware of, or might reasonably have been aware of, in the five years prior to joining the **Society**. Once the **policy** has been effected, such conditions may automatically become eligible for cover provided there has been no recurrence of symptoms, or the need for advice, medication, tests or **treatment** (from the patient's **primary care physician** or any **specialist**) for such conditions or any related conditions, for a continuous period

of two years. In the event of symptoms or a medical condition that existed in the five years prior to joining the **Society** recurring during the first two **years** of the **policy**, a further two 'clear' **years** must elapse before the condition can be considered for **benefit** entitlement.

8. What is not covered

Benefit shall not be paid in respect of:

- (a) Primary care services, or services which have been provided by a **specialist** acting in the capacity of a primary carer or carrying out primary care services.
- (b) Services that have been sought without referral from the **member's primary care physician** or without pre-authorisation from the **Society**.
- (c) **Chronic conditions** following the initial diagnosis and therapy.
- (d) **Treatment** of any orthodontic, periodontal, dental condition or prosthetic dental work, including dental implants.
- (e) Charges for **treatment** incurred in nursing homes, health spas, nature cure clinics or any similar establishments.
- (f) Any **treatment** for obesity.
- (g) Convalescence and/or rehabilitation.
- (h) **Treatment** or investigations required because of or in connection with:
 - pregnancy or child birth
 - male or female birth control
 - abortion
 - any form of assisted reproduction such as in vitro fertilisation
 - impotence
 - infertility.
- (i) **Treatment** relating to congenital and hereditary conditions.
- (j) Preventive **treatment**, screening procedures and tests. These include cervical smears, mammograms, well person health checks, vaccinations, immunisations and osteoporosis screenings together with **treatment**, screening procedures and tests because of a poor personal or family history.
- (k) **Emergency admissions** and any subsequent related **treatment** or readmission within 5 **days** of an **emergency admission** (the date and time will be obtained from the records of the admitting hospital). Please note; this 5 **day** period does not include any time spent in an Accident & Emergency unit prior to the admission and **benefits** for eligible conditions become available on **day 6**.
- (l) **Out-patient** drugs and dressings including drugs or dressings prescribed for you to take home following a hospital admission or procedure.
- (m) Surgical appliances and/or **orthoses** together with any charges incurred for the measuring and fitting thereof, together with, for example, hearing aids, spectacles, continuous positive airways pressure (CPAP) equipment, crutches, frames etc.
- (n) • Cosmetic or reconstructive **treatment**, or any **treatment** which relates to or is needed because of previous cosmetic or reconstructive surgery.

- Breast enlargement or reduction, whether or not needed for psychological or medical reasons including, but not limited to, backache.

Benefit may be available for **treatment** to restore your appearance after an accident, or as a result of surgery for **cancer**, providing that this is part of the original **treatment** for the accident or **cancer**, and that the accident or **cancer** occurred during your current continuous **policy**. You must, however, obtain **our** agreement before receiving **treatment**.

- (o) Hormone Replacement Therapy and directly related conditions.
- (p) **Treatment** that arises from or is in any way connected with excess alcohol intake or drug or substance abuse.
- (q) Regular or long-term renal dialysis in chronic or end-stage kidney failure.
- (r) Transplant operations, including investigations done before the operation, or **treatment** needed as a result of the operation. **We** will, however, cover cornea and skin grafts.
- (s) **Treatment** directly or indirectly arising from or consequent upon war, invasions, acts of foreign enemies, hostilities (whether war be declared or not), terrorism, civil war, riot, civil disturbance, revolution, insurrection, or military or usurped power.
- (t) **Treatment** for Acquired Immune Deficiency Syndrome (AIDS) and all diseases caused by HIV.
- (u) **Treatment** for sexually transmitted diseases.

(v) **Treatment** for, or which arises from, sex change.

(w) **Treatment:**

- for depression and/or
 - for stress and/or
 - for mental illness and/or
 - for psychiatric disorders and/or
 - for psychological disorders and/or
 - which arises from, or is in any way attributable to, wilfully self-inflicted injury or attempted suicide.
- (x) Any intensive care except that consequent to the **treatment** of medical conditions or surgical procedures which have been pre-authorised by the **Society**.
 - (y) **Treatment** which arises from, or is in any way attributable to, injuries sustained as a result of participating in **professional sports**.
 - (z) **Treatment** in a nursing home or hospital which has effectively become the place of domicile or permanent abode.
 - (aa) **Treatment** or drug therapy which in the **Society's** opinion is experimental and/or unproven. **We** use the National Institute for Health and Clinical Excellence (NICE) approval as the main benchmark. **Treatments** which have been clinically approved are covered. Those which have entered the NICE process but have not yet received a final decision are generally covered. If subsequently NICE fail to approve the **treatment** on purely clinical grounds, the cover for it will cease.

(bb) **Treatment** received **overseas** except with the prior agreement of the **Society**. Please note that **we** do not cover any **treatment** received in the U.S.A. or Bahamas.

(cc) **Treatment** related to the following: artificial limbs, artificial heart pumps, and cochlear implants.

(dd) **Treatment** for snoring.

(ee) **Treatment** to correct long or short sight or stigmatism together with any optical aids, including but not limited to spectacles, magnifiers, filters, etc.

9. General

9.1 The terms of the **policy** may be varied at any time by the **Society** for regulatory or legal reasons, such terms may include the following:

- the level of **premium** and the terms on which it is paid
- the **benefits** provided and the terms on which they are provided

The **Society** will give **you** reasonable notice of such changes by posting details to the address last shown for the **policyholder** on the **Society's** records. You may end the contract within 14 days of receiving this notification should you no longer be satisfied with the **policy**. However, the changes will take effect even if the **policyholder** does not receive notification for any reason.

9.2 If any dispute shall arise between the **member** and the **Society**, they shall use the **Society's** complaints procedure to resolve it. If any **member** brings details of any dispute with the **Society** into the public domain prior to exhausting the **Society's** complaints procedure, then the whole **policy** under which **benefits** are payable in respect of them will be cancelled.

9.3 If any **member** breaks any of the terms of the **policy** or makes, or attempts to make, any dishonest application or claim, the **Society** shall be entitled to:

- refuse to pay any **benefits** and
- cancel the **policy** immediately.

9.4 In certain circumstances the **Society**, subject to an objective view of those circumstances, has the right to cancel a **policy** at any time, for the following reasons:

- has failed to act with utmost good faith, or
- has acted or communicated in an abusive manner towards or with, or made any defamatory statement relating to, any member of staff of the **Society**.

The **Society** will always give reasonable notice of such a course of action.

9.5 The **Society** is not obliged to continue to offer or renew any **plan**.

9.6 When dealing with the **Society**, a **policyholder** acts on behalf of every **family member** included on his **policy**.

9.7 The **policyholder's** address will be used for all correspondence in respect of the **family members** on his **policy**, unless otherwise agreed by the **Society**. The **policyholder** must therefore immediately advise the **Society** of any change of address.

9.8 Your **policy** is governed by English law. Any dispute that cannot otherwise be resolved will be dealt with by courts in the **United Kingdom**



Exeter Friendly Society

Private Medical Insurance
UK & International

ALL DOCUMENTS ARE AVAILABLE IN LARGER TEXT AND ALTERNATIVE
FORMATS PLEASE CONTACT CUSTOMER SUPPORT ON
0300 123 3200 WITH YOUR REQUIREMENTS.



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Website: www.exeterfriendly.co.uk

Telephone calls may be recorded and monitored for quality assurance and training purposes.



INVESTOR IN PEOPLE

Exeter Friendly Society Ltd is incorporated in England under the Friendly Societies Act 1992,
registered number 91F, registered address as above.

Authorised and regulated by the Financial Services Authority, registered number 205309.