



Shared Care

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 Shared Care. 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**. 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

Co-payment

The percentage of eligible expenses incurred by a **member** and payable by the **policyholder** up to a set amount. The percentage you have agreed to pay as **co-payment** is shown on your **Policy Certificate**.

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**.

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.

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.

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**.

Orthoses

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

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), Dentist or Optician.

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

Shared Care meets the demands and needs of a person who is looking to insure against a proportion of the costs of private **treatment** for **acute conditions** that originate after joining the **Society**.

In selecting Shared Care you accept 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 options you have selected, the **benefits** available within those options and the rules described in this Policy Document and that, therefore, in certain circumstances, **benefits** may not be available for the costs of **treatment**. Even when **benefits** are available you acknowledge that, dependent on the option you have selected, you pay 10%, 25% or 50% of any eligible **treatment** costs up to the maximum **co-payment** amount.

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:

Exeter Care - A traditional **plan** designed for persons resident in the **United Kingdom**.

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 get 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 your level of **co-payment**). This means that you will pay a lower **premium** than an otherwise identical **member** on the same **plan** and option choice, provided you joined at an earlier age.

If your **plan**, **co-payment** amount or choice of **benefit** options 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** or option.

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** that offers higher **benefits**, the addition of **benefit** options, and/or a reduction of your **co-payment** amount.

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 option 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 options
- 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 option
- 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)
- annually by credit card (Visa or Mastercard only)
- monthly by Direct Debit
- 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).

Co-payment

Maximum **co-payment** amounts

- 10% **co-payment**
- maximum amount £2,000 per **year**
- 25% **co-payment**
- maximum amount £5,000 per **year**
- 50% **co-payment**
- maximum amount £10,000 per **year**

Shared Care is a **co-payment plan**. This means that you will need to pay a percentage of eligible **treatment** costs that you and your **family members** would otherwise have been covered for under your **plan** up to the maximum **co-payment** amount. The percentage that you have chosen to pay is shown on your **Policy Certificate**.

We deduct the **co-payment** from each invoice **we** receive after **we** have assessed whether or not the **treatment** costs are eligible under the terms of your **plan**. However, it is important to realise that any costs covered by your level of **co-payment** will count towards your **benefits** as if **we** had paid the invoices in full. Therefore, for example, if you submitted invoices for £300 worth of complementary therapy in a **year** under Option B, and had a 25% **co-payment** on your **plan**, **we** would only refund you a maximum of £225. If you then submitted further invoices for complementary therapy, no further **benefits** would be payable, as you would have reached your annual maximum complementary therapy **benefit**. However, you would be liable for 25%, up to a maximum of £4,925 of further eligible charges, e.g. **in-patient** admission in the same **policy year**.

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 whether you have any **benefits** available.

When the patient visits the **specialist** **we** strongly recommend that he takes along this Policy Document, as the **specialist** may need to refer to this in order to establish if the proposed **treatment** is 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**

When you have **our** confirmation that your claim has been approved, you can arrange your **treatment**. **We** may be able to negotiate a special package price for you that may be available for the **treatment** you require. If **we** are unable to source a suitable package for you, you will need to source your **treatment** yourself. However, please ensure that you check with **us** that the **treatment** you are arranging is covered under your **policy**. If you are visiting a **specialist**, **we** also suggest that you take your Policy Document and **Policy Certificate** with you, in case further **treatment** is required. This will enable you to ensure that **benefit** is available for these under your **plan**.

Payment of Invoices

Shared Care only provides cover for a proportion of eligible **treatment** costs. **We** are able to pay **our** share of the invoices directly with most hospitals and **specialists**. They can forward invoices directly to **us**, and **we** will deal with them for you.

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

We will assess the invoices to ensure that **benefits** are available under your **plan**, deduct the amount that you will need to pay according to your chosen level of **co-payment** and up to the maximum **co-payment** amount, from the **benefits** payable, and pay the **benefits** in accordance with your instructions, either directly to the hospital or **specialist** or to you.

If **we** are paying you, wherever possible **we** will reimburse you by direct credit transfer to the bank account from which **we** collect your **premium**.

We strongly recommend that you check the invoices and inform the hospital or **us** of any discrepancies. Please note that **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	£9,900	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

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 it is eligible for **benefits**. If **we** consider the condition for which you need **treatment** to be chronic, **we** will only cover **our** share of the cost of the initial investigations leading to a confirmed diagnosis, and the **treatment** needed to stabilise the condition, providing the **treatment** is covered by the **benefits** provided under your chosen option.

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 **our** share of the costs 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 28 **days** of an **emergency admission** is not covered. However, if you needed further **treatment** to stabilise the condition **we** would consider paying **our** share of the costs (provided that this is covered under your chosen option and you have **benefit** available). In order to consider this **we** usually request a medical report or ask for additional information.

Example 1 - Angina and Heart Pain

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 **our** share of the costs for these investigations. **We** will not, however, pay for the medication.

Shared Care Table of *Benefits*

This table shows the **benefits** which apply to each person covered under each option each **year**. Please refer to the particular terms of your own **policy**. Please note that where limits apply these are the **benefit** maximums.

Core	Benefit Available (including co-payment)
<i>In-Patient/Day-Patient</i> Hospital Charges	Fully Shared Payment
<i>In-Patient/Day-Patient Specialist</i> Services	Fully Shared Payment
<i>Oncology</i>	£27,500 per year
Cover Abroad	Fully Shared Payment
<i>Hospice</i> Donation	£250 per year
GP Helpline	Unlimited access to 24/7
<i>Pre-admission Tests</i>	Fully Shared Payment
<i>Out-Patient</i> Surgery	Fully Shared Payment
Option A - <i>Out-Patient Benefits</i>	Benefit Available (including co-payment)
<i>Specialist</i> Consultations, including follow-ups; <i>Diagnostic Tests</i> ; Diagnostic Imaging & Scans	Fully Shared Payment
Option B - Additional <i>Benefits</i>	Annual Individual Benefit Available (including co-payment)
Complementary Therapies (such as physiotherapy, osteopathy, chiropractic, podiatry/chiroprody, speech therapy, occupational therapy, dietician, acupuncture, homeopathy and pain clinics)	£300 per year
<i>Home Nursing</i>	£500 per year
Private Ambulance	£300 per year
Health Screens	£150 per year
Travel Allowance	£50 per year

- We will pay **our** share (according to the level of **co-payment** chosen) for any eligible, **covered** services up to the **benefit** maximums on your chosen options.
- You are responsible for paying your share of the **co-payment**, up to your **co-payment** maximum as set out in the **policy**.

Please note: your share of eligible **treatment** charges is up to £5,000 for a 25% **co-payment** option and £1,000 for a 50% **co-payment** option.

r. Please remember that your being able to claim these **benefits** will depend on **our** rules and **benefits** that are available before the deduction of your chosen **co-payment** percentage.

Benefit	Notes
Benefit	Includes accommodation , nursing, theatre fees & consumables, surgical drugs & dressings, diagnostic tests , scans, physiotherapy, pathology & eligible prostheses for in-patient treatment & day-patient treatment . (Please note that drugs or dressings to take home with you are not covered, see Rule 8 (l).)
Benefit	Surgeon's, anaesthetist's & physician's fees for in-patient treatment & day-patient treatment .
Benefit	Includes radiotherapy and chemotherapy under the management of an oncologist (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 & Day-Patient Benefits .
Benefit	For in-patient treatment & day-patient treatment in EEA countries.
Benefit	Paid as a donation to the hospice (irrespective of length of stay) if the patient requires admission for care.
Benefit	See page 24 for further information and access details.
Benefit	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 (ECG's) and a chest x-ray.
Benefit	A surgical procedure when performed by a specialist in a consulting room or at a hospital.

Benefit	Notes
Benefit	
Benefit	

Benefit	Notes
Benefit	Treatment may be undertaken only following referral by your primary care physician and administered by a practitioner whose name appears on the appropriate register.
Benefit	Payable for medical as opposed to domestic reasons and must be undertaken under the supervision of the attending specialist .
Benefit	Payable towards the cost of private road ambulance to, from or between hospitals. The use of the ambulance must be medically essential & required in connection with eligible in-patient treatment or day-patient treatment .
Benefit	Payable towards the cost of taxis &/or public transport to, from or between hospitals. The use of transport must be required in connection with eligible in-patient treatment or day-patient treatment . The cost of petrol for private vehicles is not refundable under this benefit .

customary and reasonable charges for each person on the **policy**, per **year**, up to any **benefit**

maximum, and for any charges above the **policy** maximums in any **policy year** or not covered by

up to a maximum of £2,000 for a 10% **co-payment** option,

£10,000 for a 50% **co-payment** option per **year**.

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 **our** share of the costs of the operation and any follow-ups needed, as long as **benefits** are available for these under the terms of Alan's particular option.

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 **our** share of the costs of the initial consultation and tests, providing Eve has chosen to include Option A as part of her **policy**. 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 28 **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**, or the following 28 **day** period, **we** would consider paying **our** share of the costs of further **treatment** 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 **our** share of the costs of the initial consultation and investigations, providing Deidre has chosen to include Option A as part of her **policy**. **We** will pay **our** share of the costs of the follow-up consultations until the condition has been stabilised. Again, providing Deidre has chosen to include Option A as part of her **policy**. 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 28 **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 after the 28 **day** period, **we** would consider paying **our** share of the costs 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 our share of the costs 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 **oncology benefit** limit.

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-authorised by the Society before the treatment commences

Hospice	x	Donation only according to the available benefit on your policy
Preventative	x	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	x	You are not covered for any experimental or unproven treatment such as stem cell treatment
Clinical trials	x	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	x	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 **our** share of the initial consultation and **diagnostic tests**, providing Carole has chosen to include Option A on her **policy**, the operation from her **In-Patient** and **Day-Patient benefit**, which is a fully shared payment and her chemotherapy and radiotherapy, up to the **benefit** limit of £27,500.

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 **our** share of these check-ups.

Example 2

Beverley 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 **our** share of the consultations, operation and breast reconstruction up to the **benefit** limits of her chosen **plan**. **We** will also pay **our** share of the radiotherapy and chemotherapy up to the **benefit** limit of £27,500.

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 **our** share of the consultations and operation up to the **benefit** limits of her chosen **plan**. **We** will also pay **our** share of the radiotherapy and chemotherapy up to the **benefit** limit of £27,500.

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 **benefit** limit.

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 Diagnostic tests / scans, e.g. CT, MRI, PET	⇒	NORMAL OUT-PATIENT BENEFITS - see the Table of Benefits on pages 16 and 17 for the amount available under your chosen plan
In-Patient, Day-patient or Out-patient surgery	⇒	NORMAL BENEFITS
Consultation with Oncologist 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	⇒	ONCOLOGY BENEFITS - see the Table of Benefits on pages 16 and 17 for the amount available under your chosen plan
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 16 and 17 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 16 and 17 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 Rules 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**
- 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 options within a **plan**, change to another **plan** or amend the level of **co-payment**. 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 Any request for changes to a **policy**, must be made by the **policyholder** on the appropriate form, where applicable, or in writing.

2.3 Any **member** rejoining the **Society**

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.

2.4 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.

2.5 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.

2.6 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**.

2.7 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 option within a **plan** or any change to the level of **co-payment** 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 amount of cover and/or **co-payment**, 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 amount 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 options or reduces the **co-payment** level, 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 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 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 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 The **co-payment** applies to all eligible expenses. By 'eligible expenses' **we** mean the expenses that would have qualified for **benefits** had no **co-payment** been in place. The amount of any **benefit** claimed for **treatment** that would have been payable but for the **co-payment** shall nevertheless count towards the **benefit** limits contained within the table of **benefits**.

6.6 **Treatment overseas** is only covered 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 payment 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, it is likely that your share of the costs will be greater than your related **co-payment** percentage/amount.

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 General Practitioner 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, unless Option B has been chosen and forms part of your **policy**.
- (k) **Emergency admissions** and any subsequent related **treatment** or readmissions within 28 **days** of an **emergency admission** (the date and time will be obtained from the records of the admitting hospital). Please note; this 28 **day** period does not include any time spent in an Accident & Emergency unit prior to the admission.
- (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 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**. **Benefits** are only available for **in-patient treatment** and **day-patient treatment** received in countries in the European Economic Area (EEA), i.e. Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Iceland, Ireland, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, and Sweden. 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 +44 1392 35 35 00 WITH YOUR REQUIREMENTS.



Exeter Friendly Society Limited
Lakeside House, Emperor Way, Exeter. EX1 3FD. United Kingdom

Website: www.exeterfriendly.co.uk

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