



Healthcare

Deposit Account

Your revised policy terms from 1 October 2011



In this guide

This document is to be referred to in conjunction with the Your Policy Explained document you received on joining as it replaces specific sections in your policy terms:

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Please file this document carefully with your policy documents, as together they form the Terms and Conditions of your policy from 1 October 2011.

How to make a claim

Our trained staff are on hand to make the claims process as quick and easy as possible for you and a member of our specialist medical claims team will guide you through the process step by step. The team is nurse-led with a strong knowledge base, so you can be assured that the advice you receive on your claim is completely professional and they will ensure you receive the best possible advice based on your needs and the level of cover you have.

Customary and reasonable fees

The team will ensure that the costs of your treatment are customary and reasonable so that you are not using more of your cover than is necessary and to help you get the best value from your plan. They work from a standard schedule of fees which can be found on our website. If the fees charged by your treatment

provider exceed those on the list, our claims team will work with you to source an alternative. If you choose to go with a provider whose fees exceed those on the schedule, or if you have any kind of shortfall through lack of available cover, you will be informed of any cost you need to pay yourself.



Making a medical claim

Step 1 – Visit your GP

- All claims must start with a GP referral. When your GP makes a referral (recommends you to a specialist), you should let them know that you have a policy with National Friendly. You can then discuss whether the NHS or private sector offers the most suitable source of treatment. You are also welcome to use our claims team to help you.

If your GP is unable to recommend a private specialist, we will let you know details of someone close to your home or workplace. We don't have preferred lists of hospitals or providers, so we can help you get the quality and convenience you expect from a specialist or provider.

When choosing private medical treatment, you will need to bear in mind that the fees charged by specialists and hospitals will vary, depending on who is providing your treatment, what you have done, and where. For instance, central London hospitals are likely to be more expensive than other treatment centres elsewhere in the country. Where we consider that the costs of your treatment are not customary and reasonable our claims team will help you consider alternatives.

Step 2 – Contact us

- Contact our specialist medical claims team on **0808 168 2912** (lines open 8am-6pm Monday to Friday) before making any appointments. Please have your personal reference number to hand when calling – this number can usually be found in the top right hand corner of any correspondence you have received from us.

- We will check whether your condition is covered by the policy and will ask you for the consultant's details in order that they can discuss your treatment and set up a payment agreement. We won't be able to discuss your medical details until we have received your written consent to do so.

We will send, fax or e-mail a medical consent form to you, or you can download a form from our website to save time.

- Having obtained your permission we will then ask your doctor to submit a copy of your referral, plus supporting information from any attending practitioner. We need this to determine the date of onset of symptoms and to obtain other medical information which will help us assess whether your claim can be paid by your plan.

This process can take a few days, especially if dealing by post, but if there is any delay in getting the information we need in order to make a decision on your claim, we will keep you informed and will make every effort to get a swift decision for you.

Alternatively, if your doctor has given you a copy of the referral letter, we will ask you to send or email us a copy.



Making a medical claim cont.

Step 3 – We assess your claim and give you a decision

- If you don't let us know about your treatment in advance, or you have treatment before we've authorised payment, you will have to pay the bill yourself.
- If you provide us with the information we need, including your consent for us to speak to your treatment providers, and your medical condition and available budget allows, we can authorise your claim in accordance with the terms of your policy. We may also reimburse bills you have paid if the terms of your policy allow.
- In some cases, where urgent treatment or testing is required, there may not be time to get written medical records. In such instances, if a condition is assessed as urgent you should attend A&E. You will not be covered for the costs of treatment or transfer to a private facility following emergency admission i.e. where you have been admitted via A&E (Accident and Emergency).
- We won't know for sure whether a claim is valid or that we will pay it until we have seen the medical details in the referral and we reserve the right not to pay or reimburse a claim if, for example:
 - you haven't followed the correct claims process;
 - your medical report confirms to us that your condition is not covered by the plan;
 - your condition existed before you took out cover and recurs whilst excluded from cover;
 - your condition was not disclosed on your application form (depending on the underwriting selected) and we would have excluded it from cover if it had been disclosed;
 - your treatment was not medically necessary;
 - you do not have enough cover available in your plan to meet the entire cost of the claim. In this scenario we will explain your options, including which aspects of the claim we may be able to pay.
- If we have to decline a claim for private treatment, either fully or partially, we will let you know as soon as we can, and we will discuss possible treatment options that may be available on the NHS (you will need to arrange this yourself through your GP).

If you still want to have private treatment, our claims team will explain your options, which may involve you paying bills yourself and/or switching part of your treatment to the NHS. They will try to help you get the best combination for your budget.



Step 4 – During your claim & repeat visits

- If we have agreed you have a valid claim, our claims team will keep you informed every step of the way, from booking your first appointment through to managing any follow-up treatment you inform them of.
- We also need you to keep in touch and let us know if you need to go for additional treatments, so that we can give you a decision on whether those additional treatments can be paid or not. That way, you will always know whether continued treatment is covered. If it is, we can make arrangements with your treatment provider to deal direct with us to settle the medical and hospital bills covered under your policy. This is why keeping in touch with us at each stage of your treatment is so important. Using your signed medical consent form, we will continue to liaise between you, your GP, and treatment provider.
- It is important that our claims team speaks to your treatment provider in advance to negotiate payment terms. If, for any reason, the treatment provider sends the bill to you, please forward the original bill to us as soon as possible to avoid penalties for late payment.
- If you have chosen private treatment and are likely to need multiple visits to your treatment provider e.g. for physiotherapy, please call us at the start of each course of treatment to check whether you're covered. You will need to get a GP referral before each course, and if you get a recurrence of a problem, please call us before you arrange sessions as we need to check that you are covered and advise you accordingly.
- We will pay the costs of an initial assessment followed by three further sessions, if required, as long as pre-authorisation has been obtained from the claims teams. If any more sessions are required then you must contact the claims team to obtain further authorisation. For claims requiring more than eight sessions, you must contact the claims team who will request a treatment plan from the therapist before any further sessions are authorised.

We do this to discuss with you and your specialist any extra treatment which may be necessary to cure you and will re-assess the claim against the cover limits of your plan. If we give you the go-ahead on your claim and if the treatment provider is happy for us to do so, we will settle your bill at the end of your treatment.

If you attend more than eight sessions without authorisation you will need to pay the bill yourself.





Making dental & optical claims

Step 1 – Check your treatment is covered

- After holding your policy for 6 months, you are eligible to make dental and optical claims. One optical claim can be made every other calendar year on accounts for a single adult or child and one claim in each calendar year on all other accounts. One claim in this instance means one receipt.
- To check whether the specific type of treatment you need is covered by the policy please read the 'Included' and 'Excluded' lists on pages 10-11, or you can check by calling the Dental & Optical claims team on **0808 168 2912**.
- Please ensure that your receipt gives details of your treatment to avoid unnecessary delays in payment. All receipts should clearly show:
 - The name, address and qualifications of the treatment provider, so we can contact them.
 - The name of the person who received the treatment.
 - Details of treatment including date, description of treatment and cost. If an itemised receipt of the treatments received is not possible, a separate breakdown should be provided by the practitioner.
 - Confirmation that the practitioner has been paid for the treatment.

Step 2 – Receive your treatment and keep your receipt

- If we have confirmed your claim will be covered, you should go ahead with your treatment and pay any invoices you receive.
- As the Society does not settle dental and optical claims directly to the treatment providers, be sure you have a receipt for the payment of your treatment as you will need this to claim the money back from us. If you have treatment which is not covered by your plan then we will not reimburse you.





Step 3 – Submit your claim form with receipt

Name, address and qualifications of practitioner

Details of recipient of treatment

Details of treatment including date, description of treatment and cost

Dental Clinic

BDA REGISTERED
4-5 WORCESTER ROAD
BRISTOL BS8 3JL

MR A.N. OTHER, 11 HIGH STREET,
ANYTOWN A1 2MS

03/02/10 TREATMENT
£18.00

12/02/10 TREATMENT
£18.00

19/02/10 TREATMENT
£18.00

RECEIPT PAID IN FULL
19/02/10

Confirmation that the practitioner has been paid for the treatment

- All claims must be submitted with the original detailed receipt to National Friendly within 3 months of the final treatment date or the date on which the last appliance was supplied e.g. glasses.
- You can download a dental or optical claim form from our website. Alternatively contact our claims team who will be happy to email or post one out to you.
- For valid claims we will reimburse you for the appropriate cost incurred in accordance with your policy terms. This will be paid by BACS directly into your account as specified. Usually this process will take no longer than 5 working days to process plus 3 days to reach your account.
- We keep all receipts, so you should take a copy if for any reason you need a record of the details.





Making an NHS stay claim

Step 1 – Check you're covered

- If you have stayed in an NHS hospital, then provided you had the opportunity to choose private treatment under our terms, you may be able to claim a cash payment for your stay. Accident and emergency admissions would not normally be covered – see 'Included' and 'Excluded' lists on page 11.
- Check whether your claim will be covered by speaking to our claims team on **0808 168 2912**. Please have your personal reference number to hand when calling. This number can usually be found in the top right hand corner of any correspondence you have received from us. The claims team will send you a claim form for your stay or you can download one from our website. You can also submit a discharge report from the hospital.

Step 2 – Submit your hospital form

- If the claims team has confirmed your claim will be covered, then following your stay you must forward to us your completed hospital form or discharge report, which contains details of your stay, in order for us to arrange payment.
- All valid claims will be paid after proof of your stay has been submitted.
- Upon receipt this will normally take no longer than 5 working days to process plus 3 working days to reach your account.





What's covered and what's not

Medical Cover: Included

- In-patient, day-patient or out-patient treatment for acute medical conditions other than those on the excluded list or conditions that are directly linked to those on that list.
- Operations (including minor ones for ear, nose and throat, carpal tunnel, adenoids and tonsil removal), surgeons' fees, anaesthetic.
- Cancer treatment, including chemotherapy, radiotherapy, oncology and cancer surgery.
- Heart surgery.
- Oral surgical procedures, administered under general anaesthetic.
- Consultations, diagnosis, pathology and other hospital tests that your GP or other treatment provider has recommended.
- Scans of all types (CT, MRI, etc.).
- Therapies for acute conditions: alternative medicine in the form of homeopathy, chiropractic and osteopathic work and acupuncture, if administered by accredited providers. We also cover chiropody, podiatry and physiotherapy treatments, again where carried out by qualified practitioners.
- Psychiatric conditions: we will pay for a maximum of 6 pre-authorised out-patient consultations or treatments from a specialist for conditions we deem to be acute.

- Nursing at home by a qualified nurse: we will pay up to a maximum of six weeks a year provided this is required as part of your treatment for an acute condition or for treatment of an acute worsening of a chronic condition.
- Private land ambulance where deemed necessary by a specialist.

Medical Cover: Excluded

- Any costs in connection with childbirth, fertility testing or infertility treatments, or any treatment to help prevent, or help recover from, pregnancy.
- Residential stays in a hospital, or convalescence of any kind. We will only pay for short-term stays necessary because of an acute medical condition or injury.
- Drugs and dressings for out-patient or take home use.
- Gender re-assignment (sex change).
- Preventative screening and tests for inherited conditions, cervical smears, mammograms, wellperson checks, vaccinations, immunisation and musculoskeletal screenings such as those for osteoporosis.
- Cosmetic treatment or plastic surgery, unless this is reconstructive treatment following an illness or injury sustained whilst you hold a plan with us which itself would have been covered under the policy.



What's covered and what's not cont.

Medical Cover: Excluded Cont.

- Any costs that have already been paid from another source, such as another insurer or through another injury claim.
- Congenital abnormalities (abnormalities you were born with).
- Dental and optical treatments other than for conditions which require surgical intervention under general anaesthetic.
- Hormone replacement therapy (HRT).
- Psychiatric care as an In-patient.
- Kidney dialysis in either chronic or end stage kidney failure (we would only pay for dialysis to treat acute reversible kidney failure or immediately before or after a kidney transplant).
- Organ transplants and donations.
- Medical appliances, unless these have been inserted or attached as part of a medical procedure.
- Treatment for any injury deliberately inflicted on yourself.
- Routine testing, treatment or any other service from your GP.
- Treatment such as hydrotherapy and detoxification in health clinics, spas or clinics that promote general health rather than curing specific conditions.
- Treatment from a specialist if your GP does not support your claim.

- Treatments you receive overseas.
- Treatments or remedies carried out by bodies we do not recognise and approve in advance.
- Treatment for weight loss or treatment required as a result of obesity.
- Treatment for sleep disorders including sleep apnoea.
- Learning difficulties, including dyslexia, development problems, or behavioural problems such as attention deficit hyperactivity disorder.

Dental Cover: Included

- Fillings
- Extractions
- Bridges
- Dentures
- Crowns
- Inlays
- Dental implants
- Root canal treatment

Dental Cover: Excluded

- Check-ups (unless they are part of the same bill as other covered treatments).
- Any treatment not listed under 'Included' above, including, but not limited to, cosmetic dental treatments, scale and polish (or other cleaning of teeth and gums), braces and bite guards.
- Dental surgery under general anaesthetic will be paid under Medical Cover under the terms and conditions described in that section.



Optical Cover: Included

- New glasses or contact lenses
- Repairs to glasses
- Prescription sunglasses
- Corrective eye treatments by lasering. Other eye operations under general anaesthetic will be treated as part of your Medical Cover.

Optical Cover: Excluded

- Any item or treatment not shown on the 'Included' list above.
- Laser eye treatment in the first 24 months.

NHS payments: Included

- Claims for NHS benefits are not subject to an own share contribution from your personal deposit account.
- You can claim a cash payment for overnight or day case treatment undertaken in an NHS hospital. You can claim ten such payments a year per policy in circumstances where you could have chosen a private hospital. A&E admissions won't normally be covered, though we may consider a claim if a second night's stay becomes necessary after an accident and emergency admission.
- If you have a child policy, you and your child can claim when you need to stay with your child is in hospital overnight. This counts as two allowances out of the maximum of ten.

- Day case treatments are those which for medical reasons mean you have to go into a hospital or day patient unit because you need a period of clinically supervised recovery but do not have to stay overnight.

- Our claims team will be able to offer a cash sum at 25% of the standard private treatment cost if you elect to have your treatment on the NHS providing:

- Your treatment is on a list held by our claims team.
- You would be able to cover the cost of the private alternative in full from your deposit balance and any top-up available.
- You are not excluded from cover under your policy terms.
- It is within the minimum and maximum sums we have set.

You are under no obligation – the offer merely extends a choice over how you spend your cover.

NHS payments: Excluded

- Claims for NHS hospital stays where you have received treatment for which you are not eligible under the terms of your policy e.g. pregnancy, pre-existing conditions, treatment of chronic conditions.
- Out-patient treatment including physiotherapy, chiropractic etc.



What's covered and what's not cont.

General exclusions

- Any condition that has come from being infected by human immunodeficiency virus (HIV) and/or any related illness, including acquired immune deficiency syndrome (AIDS).
- Alcoholism, alcohol abuse, solvent abuse, drug abuse or addictive conditions of any kind or the treatment of any condition developed as a result of such abuse.
- Accident and emergency admissions – but see NHS Included section on page 11.
- Injuries or illness arising from war, or war-like operations (civil or otherwise and whether or not war has been declared), military, paramilitary or terrorist activity (including the effects of radiobiological, biological or chemical agents).
- Injuries or illness sustained as a result of your actual involvement in criminal activity and/or public-order offences.
- Injuries or illness sustained or related to taking part in a dangerous sport or activity such as scuba-diving, gliding, parachuting, parasailing, paragliding, mountaineering, or motor sports. If you are not sure what we class as a dangerous sport, please contact us.
- Any incapacity sustained while taking part in any professional or semi-professional sport (one you are paid for).
- Treatment of chronic conditions. These are conditions that are long term with no likely cure.
- Sexually transmitted disease or sexual dysfunction.

Loyalty rewards

The personal deposit account is not a savings account so does not pay interest. However, if the overall claims experience for all healthcare contracts is better than expected, we expect to distribute a share of any surplus to your policy.

Loyalty rewards when applied will be a discount on the part of your fixed monthly premiums that goes to fund your policy. This means that less of your monthly premium will fund your policy and more will go into your personal deposit account. This will not affect your monthly premium.

Each year, the National Friendly Board will decide on and monitor the discount rate and will take into account all claims made and likely to be made against the scheme. Discounts, when declared will be applied on 31 December, based on your deposit account balance on 1 January of that year.

No surplus will be distributed in the first 5 years of the policy. In addition, in some years where the level of claims and other expenses prevent it, there may be no surplus to distribute. If this happens the discount rate will be zero.



Alterations to your policy terms

We may change these terms and conditions to make sure that they comply with law or regulation. We may also change the terms and conditions at any time where it is reasonable to do so:

- (a) as a result of product or system development;
- (b) because of changes in the cost of providing a service to you (for example where there is an increase in tax rates);

- (c) to allow us to administer the policy more efficiently; or
- (d) to change anything which is unclear or incorrect.

We will always write to you and let you know of any changes as soon as we can – and if you tell us within 30 days that you do not agree to the changes we will cancel your policy.

Glossary of words & phrases

Accident and Emergency Treatment (A&E):

If you need to go to hospital immediately because you're suffering acute symptoms from an illness or accident, or if you go to a hospital ward for unplanned urgent treatment.

Acupuncture: A treatment involving inserting needles in the skin or muscle to relieve conditions such as pain, anxiety, allergic reactions, sinus and skin problems.

Acupuncturist: A doctor who is also a Medical Member or an Accredited Member of the British Medical Acupuncturist Society and recognised by us as being fit to carry out such treatment.

Acute condition: A disease, illness or injury that is likely to respond quickly to treatment that aims to return you to the state of health you were in before or which leads to your full recovery.

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

Chiropody: The treatment of feet, nails, corns and bunions.

Chiropractic treatment: A treatment that involves gentle hand movements, known as adjustments, which concentrate on the spine and associated nerves.

Chiropractor: A practitioner on the Register of Chiropractors kept by the General Chiropractic Council as required as part of the Chiropractors Act 1994, and recognised and agreed by us.

Chronic condition: 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 needs ongoing or long-term control or relief of symptoms.
- You need to be rehabilitated or specially trained to cope with it.
- It needs long-term monitoring through consultations, check-ups, examinations or tests.





Glossary of words & phrases cont.

Consultation: A meeting with a medical specialist to find out more about a medical condition and decide how to treat it.

Day case treatment: Treatment which, for medical reasons, means you have to go into a hospital or day patient unit because they need a period of clinically supervised recovery but do not have to stay overnight.

Day-patient treatment: Treatment for which you have to go into a hospital or day-patient clinic/unit because you need time to recover under medical supervision, but for which you do not need to stay overnight.

Deposit account: See Personal Deposit Account.

Diagnostic tests: Any investigation, such as a blood test or x-ray, which might find or help to find the cause of your symptoms.

EMA: The European Medicines Agency.

Fixed monthly premium: Monthly premium of which 50% goes into a personal deposit account. The premium is fixed for life.

GP: A general medical practitioner (doctor) who has a Certificate of General Practice Training and is registered with the General Medical Council in the UK.

Hospital: A private hospital in the UK which is registered in accordance with UK law and which has specialist facilities for major surgical operations. Or any hospital or establishment that we agree is appropriate for providing treatment.

Hospital charges: Charges for accommodation, nursing care, drugs and dressings, diagnostic prosthesis and operating costs.

In-patient treatment: Treatment which, for medical reasons, means you have to stay in hospital overnight or longer.

MHRA: The Medicines and Healthcare products Regulatory Agency.

Moratorium: The period during which we will not pay for pre-existing conditions that you knew about when you joined.

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

Nursing at home: If you have difficulty getting to in-patient or out-patient appointments, you may need to get treatment at home. You are covered to receive treatment at home by a qualified Nurse (see definition above).

Oncology: The field of medicine specialising in the study, diagnosis and treatment of cancer.

Osteopath: A practitioner on the Register of Osteopaths kept by the General Osteopathic Council as required as part of the Osteopaths Act 1993, and recognised and agreed by us.

Out-patient treatment: Treatment given at a hospital, consulting room or out-patient clinic where you do not go in for day-patient or in-patient treatment.

Own share: Your set percentage paid towards each claim from your personal deposit account.



Personal Deposit Account: Your own account that 50% of your fixed monthly premium goes into and from which you will fund your own share of a claim.

Podiatry: Treatment of lower extremities including foot, ankle, knee and hip.

Physiotherapist: A physiotherapist regulated by and registered as practising with the Health Professions Council and recognised by us.

Policy schedule: The document containing the specific details of your Healthcare Deposit Account. We give you your policy schedule when you join, and we will update it whenever your account or other details change.

Pre-existing condition: Any disease, illness or injury that you have had medication, advice or treatment for, or that has produced symptoms, whether or not it was diagnosed, in the five years before joining this Healthcare Deposit Account.

Private land ambulance: A purpose-built vehicle run by a recognised private ambulance service approved by us.

Sign: Any objective evidence of disease which can reasonably be recognised by a patient, healthcare professional or other.

Specialist: A medical practitioner, under the age of 70, who is registered under the Medical Acts and is a specialist in the treatment you are referred for. They must hold a certificate of Higher Specialist Training in their speciality that is issued by the Higher Specialist Training Committee of the appropriate Royal College or Faculty. They will be or will have been a National Health Service Consultant and must be recognised as a specialist by our claims team.

Symptom: A sensation (e.g. pain) felt by the patient and caused by a disease.

Treatment: Surgical or medical services (including diagnostic tests) to diagnose, relieve or cure a disease, illness or injury.

UK: For the purpose of this policy this means England, Scotland, Wales, Northern Ireland, the Channel Islands and the Isle of Man.





To request a copy in Braille, large print or audio

Call 0800 195 9245

(8am-6pm weekdays, calls are recorded for quality purposes)

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