

Your policy explained

Group Healthcare Deposit Account

Part 1: Policy Summary

This is your guide to the Group Healthcare Deposit Account scheme offered by National Friendly. This is only a summary of the main features, so to fully understand the Group Healthcare Deposit Account please read our terms and conditions in Part 2.

1. What does the Group Healthcare Deposit Account offer?

- The Group Healthcare Deposit Account provides Private Medical Insurance (PMI) and aims to give you, the employee, the choice between the NHS and private treatment if you become ill or get injured.
- Options are available to cover your family too.
- It offers comprehensive cover for a range of benefits including private consultations, surgery, recognised alternative therapies, cancer and heart treatment, hospital fees, dental and optical bills and cash payments for an NHS hospital stay.
- It offers worksite support to benefit your health, including counselling in times of stress, health screening and eye tests.
- Premiums are paid by your employer and set the level of cover available to you.
- 75% of each monthly premium goes towards the cost of running the scheme. The other 25% goes into your own personal deposit account.
- Your personal deposit account is what makes this healthcare special. It means you can build up a fund to pay for healthcare cover at your own pace. When you need to claim, your personal deposit account will pay 10% of the cost*, National Friendly will pay the rest.
- The more money you have in your personal deposit account, the more of your annual limit of cover you (and any other covered family member) will be able to claim.
- We will pay the total cost of any claim provided you have enough cover and have enough in your personal deposit account to fund your share of the claim. See pages 12-13 for further details. Also see the top-up section below.
- For the first ten years, your employer will pay for a top-up premium of either £10, £15 or £20 a month. This will give you an extra £30,000, £45,000 or £60,000 respectively of medical cover in case you don't have enough money in your personal deposit account to meet your share of a claim.

* own share percentage is subject to review and can change in the future

- Monthly premiums are reviewed every 5 years starting from the issue date of the group scheme. Top-up premiums are also subject to 5 year reviews and your employer will also be given terms to extend top-up beyond year 10.
- You and your employer can also boost your personal deposit account balance at any time by paying in extra money. This will increase the amount you can claim in the future from the level of cover your employer has chosen for you.
- You can only withdraw money from the personal deposit account that you have paid in and not used towards a claim.

2. Who can join and for how long?

To join the Group Healthcare Deposit Account scheme you must be employed by the company paying the premiums. Schemes will consist of a minimum of three employees, all members of the scheme must be under age 70. Membership of the Group Healthcare Deposit Account scheme will end on your 70th birthday, but you can keep healthcare cover for life by taking over payment of the premiums and transferring to an individual policy after you've left the company scheme – see 'What happens if your employee leaves their current employment or reaches 70?' on page 30 for further details.

By joining the Group Healthcare Deposit Account scheme you will become a member of National Friendly and will therefore be subject to its Rules (available on request) and benefit from its mutual status.

3. How much does it cost?

Your monthly premiums

Your employer will pay monthly premiums, which will be fixed for 5 years at a time. The premium will depend on the level of cover your employer chooses and the age of each employee. The premium will be higher if an employee's family is covered too.

Top-up premiums

For added cover, your employer will pay an additional top-up premium of £10, £15 or £20 a month on each plan. You will be informed which top-up premium your employer has chosen in your personalised policy schedule.

We will offer terms to your employer for extending your top-up cover at the 10 year anniversary of the issue date of your employer's scheme.

Tax implications – P11D benefits

The premiums and any other payments to this policy paid by your employer will be assessed as a benefit in kind, and you may have to pay income tax on the amount – see page 31 for further details. your employer should be able to give you more information on this.

Premium reviews

Both monthly premiums and top-up premiums will be reviewed on the 5th anniversary of the date on which your employer's scheme was issued. Premiums may increase if claims or other costs across the scheme are higher than we anticipated when it was priced, or if medical advances specifically merit a change. We'll assess the premium fairly and will advise your employer in advance of each 5 year anniversary of the group scheme and whether or not your premium will increase.

4. How does the employee make a claim?

To make a claim you, or other family member where applicable, should call us on **0808 168 2912** (8am-6pm weekdays) or write to us at Claims, National Friendly, 4-5 Worcester Road, Clifton, Bristol BS8 3JL. See page 28 for further details.

5. What's not covered?

Here is a summary of conditions we don't cover. You'll find full details on what is and what isn't covered on pages 19-22.

- Conditions specifically excluded on your policy schedule based on health problems disclosed on joining, OR pre-existing conditions which fall within the two year exclusion period for moratorium underwriting.
- Cosmetic treatments.
- Costs already settled as part of another insurance or injury claim.
- Dental check-ups, unless they are part of another treatment covered by this policy.
- Dental and optical claims in the first six months of your policy, or laser eye treatment claimed in the first two years.
- Dental scale and polish.
- Out-patient drugs and dressings.
- GP charges for signing forms, routine treatments or routine tests.
- Health screenings in the first six months.
- Health spas.
- HIV or AIDS related conditions.
- Long-term or chronic conditions, but you may be able to claim for acute (easily and quickly treated) episodes of a chronic condition.
- Overseas treatment.
- Pregnancy or fertility-related treatments.
- Surgical or medical appliances, unless they are part of another medical procedure covered by this policy.

6. What else does the employee need to know?

Limitations of access to the personal deposit account

You cannot withdraw any cash paid in by your employer. On leaving the company or reaching age 70 you can take up a plan of your own.

Please note: We may cover different conditions to your current provider. If you or any family member has suffered from a condition before switching to our plan, it may not be covered.

If you have a complaint

We are a mutual association that exists to support our customers and we aim to provide the highest standards of service. If we fall short at any time and you wish to make a complaint, please contact us on:

- **0808 168 7775** (8am-6pm weekdays)
- Email compliance@nationalfriendly.co.uk
- Fax 0117 980 9358
- Or write to Compliance Department, National Friendly, 4-5 Worcester Road, Clifton, Bristol BS8 3JL.

A copy of our complaints procedure is available on request or from www.nationalfriendly.co.uk

If you make a complaint and are dissatisfied with our response, you may be able to ask the Financial Ombudsman Service for an independent review:

- Financial Ombudsman Service, South Quay Plaza, 183 Marsh Wall, London E14 9SR.
- Telephone **0845 080 1800**.
- E-mail complaint.info@financial-ombudsman.org.uk
- Website www.financial-ombudsman.org.uk

Please remember the Ombudsman Service cannot deal with your complaint until you have first raised it with us. In making any complaint, your right to take legal proceedings is not affected.

The Financial Services Compensation Scheme

The Financial Services Compensation Scheme (FSCS) protects customers of nearly all financial services in the UK including customers of this policy. Depending on your policy and the circumstances of any claim, you may be entitled to compensation from the FSCS if we can't meet our obligations, for example to pay what we owe.

If you are entitled to a claim, most insurance policies are covered for 90% of the claim with no upper limit. You can ask for more information from the FSCS on 020 7892 7300 or at www.fscs.org.uk.

Right to cancel

This policy has been purchased by your employer and only the employer is entitled to cancel it. You may withdraw from the scheme at a later date, details of which are provided in "What if you decide you don't want this cover any longer?" in the terms and conditions.

Part 2:

Terms and Conditions

This is your complete summary of the Group Healthcare Deposit Account from National Friendly. It forms the legally binding terms and conditions of the policy. Please keep this information in a safe place with your policy documents.

The policy is available to you (and your dependants if you wish) until age 70, or until you leave the company if earlier. It is designed to give you the opportunity to choose between private and NHS treatment. If your employer agrees to cover children, they will stay on the policy until age 21.

This booklet details the terms and conditions under which your plan will operate and therefore forms the contract between National Friendly and the employer. It will make reference to the employer as well as the employee throughout.

You will, as an employee, have a policy schedule that details your level of cover and any specific exclusions that apply, i.e. conditions that will not be covered for you and/or your dependants.

You should read this document carefully and ensure that you understand the policy before deciding whether or not to join. We would like to draw your attention to a few sections that will be of particular value to you:

Page 11-12	How much you can claim.
Page 14-17	A detailed list of what we do and do not cover.
Page 22	Details of our cancer cover.
Page 23-24	How to claim.

Please let us know, as soon as possible, if any personal details change.

1. Your Group Healthcare Deposit Account

This policy is designed for you, the employee, and your employer has agreed to pay a monthly premium in order to purchase individual cover for you.

The policy runs until you reach age 70, or until you leave the company if earlier. It is designed to give you the opportunity to choose between private and NHS treatment. If your employer agrees to cover children, they will stay on the policy until age 21.

Responsibility of the employer

- letting us know if the employee or any member of their family wishes to join or leave the scheme. We will respond accordingly.
- making the monthly payments but only during the period of employment.

Responsibility of the employee

- to notify us (within 1 month) of leaving the employment of the employer and/or gaining a new employer.
- to make a decision (within 3 months) of leaving employment as to whether to continue with an individual policy or terminate the policy. See page 30 for further details.
- to notify us as soon as your name or address is to change.
- you, the employee, will be responsible for the conduct of any dependant on the plan.

The account

Even though the policy is paid for by the employer, each account and its benefits will be in your name, as an employee.

Basic workings

Your employer agrees to pay a monthly premium into your account while you are their employee. Part of that money goes into a cash deposit account and part to National Friendly as an 'insurance premium' to pay any claim you may make.

The amount you can claim will depend on the level of cover your employer chooses, the amount you have in your deposit account, and the level of top-up cover you have. When you leave your employment you may take an individual account and continue to make payments yourself – see 'What happens if I leave...' on page 30 for further details.

As an employee:

- You need to understand that a 10% share of each claim will come from your personal deposit account, please see page 13.
- A top-up allowance will supplement medical claims in the first 10 years of the plan. At the end of ten years a chance to extend the top-up will be offered to your employer.
- You will have the option of paying the premiums the employer pays on your behalf in the unlikely event your employer is unable to do so.
- You will be responsible for making sure a claim is paid if we cannot pay the treatment provider directly (this will be refunded to you).
- You cannot withdraw any cash paid in by your employer.

For the detailed conditions attaching to the basic workings above, please read the whole of these policy terms and conditions.

2 . Monthly premiums

Monthly premium

The premium chosen from the table below will be the premium paid for at least the first five years of your employer's policy. It will be reviewed after five years. The review will look at the claims experience of your group, and of the healthcare scheme as a whole over the preceding five years. Only if claims or other costs across the scheme are higher than were anticipated when we priced it, or if medical advances specifically merit a change, will we increase your premiums at the five year review.

Your employer will be advised of your premium for the next five years of their policy. It may be the same or it may be higher. Your employer will then decide whether they wish to continue on the terms we offer. We will not review the premium for a further five years. Premium reviews will be carried out on each five year anniversary of your group policy.

You should also see the section on top-up premiums for details of similar premium reviews.

Employee's annual limit of cover

Fixed monthly premium	Medical cover	Dental and optical cover	NHS hospital stay payments
£30	£15,000	£450	£300 = £30 a night
£40	£20,000	£600	£400 = £40 a night
£45**	£22,500	£675	£450 = £45 a night
£50	£25,000	£750	£500 = £50 a night
£60	£30,000	£900	£600 = £60 a night
£70	£35,000	£1,050	£700 = £70 a night
£75**	£37,500	£1,125	£750 = £75 a night
£80	£40,000	£1,200	£800 = £80 a night
£90	£45,000	£1,350	£900 = £90 a night
£100	£50,000	£1,500	£1,000 = £100 a night
£110	£55,000	£1,650	£1,100 = £110 a night
£120	£60,000	£1,800	£1,200 = £120 a night
£125**	£62,500	£1,875	£1,250 = £125 a night
£130	£65,000	£1,950	£1,300 = £130 a night
£140	£70,000	£2,100	£1,400 = £140 a night
£150	£75,000	£2,250	£1,500 = £150 a night
Also available in £10 increments up to			
£200	£100,000	£3,000	£2,000 = £200 a night

Listed premiums inclusive of Insurance Premium Tax at 5%.

**See "Covering an employee's dependants" page 9

Minimum monthly payments

These will be based on your, the employee's, age on joining. These are minimum premiums only – your employer will decide on your actual premiums. The maximum premium is £200 a month.

Employee's age	Minimum premiums
under 40	£30 a month
40-49	£40 a month
50-59	£50 a month
60-64	£60 a month
65-69	£80 a month

Please note:

- These are the maximum levels of cover we will pay in any calendar year, but the actual amount you* can claim will also depend on your personal deposit account balance at the time of claim, since that account will fund 10% of the claim.
- Only one optical claim can be made on the policy every other year.
- You* can claim a maximum of 10 NHS hospital overnight stays each calendar year.
- You* can claim an additional £350 for Health Screening. See page 18 for further details.

*dependants share these allowances – they are not per person.

Covering an employee's dependants

If your employer chooses to cover your dependants, your employer will pay a multiple of the employee rate. The multiples are as follows:

- Couple (adding a partner) 2 x the employee rate
- Individual + Children (adding a child or children) 1.5 x the employee rate
- Couple + Children (adding a partner plus child or children) 2.5 x the employee rate

Here's an example: Your employer elects to pay the minimum rates available, so a 34 year old would have a premium and accompanying benefits at £30pm + the minimum £10 top-up (see 'Top-up premium' below).

A 34 year old with a partner and children can be covered from £75pm + £10 top-up.

We will cover a maximum of five children on a family plan. Children will be removed from the plan at age 21. Anyone leaving the Group Plan can apply to join one of our Individual Healthcare plans.

Top-up premium

Your employer has the choice of either £10 a month, which provides an extra £30,000 medical cover, £15 a month which provides £45,000, or £20 a month, which gives you £60,000 of additional cover.

Top-up cover is payable in circumstances whereby your deposit account alone is insufficient to fund your treatment, and has been exhausted. Top-up is payable for covered private treatments.

Please note: none of this top-up premium goes into your personal deposit account; it all goes to increase the amount of insured cover.

We have set a top-up premium for the first ten years of your employer's plan. This will be reviewed after five years. The review will look at the claims experience of everyone who has the same policy as you. Only if claims across your group, or other costs across the scheme as a whole, are higher than were anticipated when we priced it, or if medical advances specifically merit a change, will we increase your premiums.

At the five year review, your employer has three options

- 1 To continue with the amount of top-up still remaining on your policy, but at the premium level determined following the review.
- 2 To reset your top-up to its full amount (e.g. £45,000). The premium will be that which applies at the review date plus any additional medical loading. You will be underwritten at this stage and we could apply medical exclusions if deemed necessary.
- 3 To decline the new terms and cancel the policy.

Your employer will make this decision, at each review, for all members of the group. After ten years, we will offer your employer the chance to extend your top-up cover for a further ten years, but the premiums and level of cover applicable at that date may be different from those currently available. The initial 10 year top-up cover cannot be changed other than at a five year or ten year review.

Top-up is an integral part of your policy, and once set, your employer cannot stop paying for it without closing the policy itself, even if you exhausted the whole of your top-up cover.

Please note: None of this top-up premium goes into your personal deposit account, it all goes to increase the amount of insured cover. Your employer will choose which top-up amount they wish to pay; this will be outlined on your policy schedule.

The impact of claims

We will pay claims made by you and your dependants based on your ability to fund 10% of the claim from your deposit account. Each employee and dependants will also claim from one top-up allowance per policy.

Changing the premium to change the level of cover

Your employer can increase the monthly premiums for each employee by one level each year without additional underwriting. For a couple the permitted increase is two levels without underwriting as in the multiples shown above. If a higher increase in cover/premium payments is required we may require each employee to go through an underwriting process and ask for medical details.

What happens if a payment is missed?

If your employer misses a monthly premium your Group Healthcare Deposit Account will not cover you for any claim until the outstanding premium has been paid. We will tell your employer as soon as any payment is missed. If three months' premiums are owed at any stage, your Group Healthcare Deposit Account will automatically close and you will not be able to re-open it. If your policy is automatically closed, we will write and tell you, and your employer. You can transfer any money you have paid into the personal deposit account within 28 days, or we will move it to a holding account. However, we will do everything we can to avoid the above eventuality. We will obviously correspond with your employer as soon as any payment is missed. We will let you know in the unlikely event that non-payment is not corrected and your cover is under threat.

3. Your personal deposit account

How your personal deposit account works

Your fixed monthly premiums are divided into two parts. 75% helps fund the cost of this healthcare scheme. The other 25% goes into your own personal deposit account. So if your employer decides on a fixed monthly premium of, say £60, you will be building your personal deposit account by £15 a month. When you need to claim, provided your personal deposit account will pay 10% of the cost, we'll pay the rest. The more money you have in your personal deposit account, the more of your chosen level of cover you'll be able to claim. Any money used from your personal deposit account to pay your share of a claim will show as a deduction on your annual statement. Please also refer to "Your top-up" – see page 14.

Boosting the balance – extra monthly or lump sum payments to the personal deposit account

Both you and your employer can increase the amount of cover available to you by paying in, at any time, extra money on top of the fixed premiums paid by your employer. None of these extra sums go towards the cost of running the scheme, they all go into your personal deposit account. Both employer and employee can pay as much as they want, whenever they want. We want to help you build up a balance while you're in good health, to enable you to claim the maximum level of cover if you need to, especially if your family is covered. The employer and employee can call us on **0800 195 9245** to set up an additional monthly direct debit or to make a lump sum payment by debit card over the phone. Alternatively, either employer or employee can send a cheque made out to National Friendly.

Additional payments made into your deposit account will always be used after all other money in the account when paying for a claim. In addition, employer payments will be used before employee payments.

Please note: The employer or the employee can make deposits at any time, but we will not be able to use any additional deposit payments to cover a claim for a complaint you knew about when such deposits were paid. This is to protect the fund that we use to pay all claims and to make sure that all our Group Healthcare Deposit Account holders are treated fairly and get the cover they are eligible for.

Withdrawing cash from your personal deposit account

Your employer cannot withdraw cash from your account whilst you are still part of the Group scheme. You won't be able to withdraw any cash from the account which your employer has paid. You can only withdraw money you have paid in. However, you should also read 'What happens if I leave my current employment or reach 70?' – see page 30.

Helping you keep track of your personal deposit account

We will send you a statement once a year. You can also ask for your balance over the phone or for an extra statement whenever you wish. We want to make it as easy as possible for you to check how much you have in your account.

4. How much you can claim

The amount you (or covered dependants) can claim depends on:

- The level of cover.
- There being sufficient money in your employee's personal deposit account to fund 10% of a claim.
- The level of your top-up cover.

If you have already been paid, or you're due to be paid, in full by another insurer for the same claim we will not pay the claim.

Your level of cover

Please see the table on page 9 to check the maximum level of cover available for the chosen monthly payment.

Your own share of each claim

Your personal deposit account will pay a 10% share of each claim.

The 10% share is not necessarily fixed forever and we reserve the right to change it up or down. However, we will only change it in exceptional circumstances, for example if there are unusually heavy claims across the whole of the Group Healthcare Deposit Account policy base. We will never change the percentage you have to pay just because you personally have made more claims than expected.

Here's a tip: To find out how much you can claim based on how much you have in your personal deposit account, simply multiply the personal deposit account balance by ten.

E.g. If Ms R has a balance of £200 in her deposit account, she multiplies this by ten.
 $£200 \times 10 = £2,000$, so she can claim a maximum of £2,000.

N.B. The maximum you can claim will depend on the chosen level of cover.

What happens if you don't have enough in your personal deposit account for your share of a claim?

In this case we will offer you a 'pro rata' arrangement – in other words we will pay a smaller proportion of the amount they are claiming.

Here's an example: Ms C is a 35-year-old employee in this scheme who is claiming £2,500. Her own share of the claim is 10%, which is £250. But she only has £200 in her personal deposit account.

Because she only has £200, her 10% share will only allow her to claim a maximum of £2,000. So we make Ms C a pro rata offer of £2,000. £200 will come from her account as her 10% share and we will pay the other 90% of £1,800, making £2,000 in total.

Of course we let Ms C know what we can pay before she has her treatment, so that she can decide if she can find the extra £500 from elsewhere before incurring the cost.

This example assumes that Ms C no longer has the top-up cover.

Your top-up

We know it takes time to build up your deposit balance, so, for an extra £10, £15 or £20 a month for the first ten years each employee will get what we call the top-up. It gives you an extra £30,000, £45,000 or £60,000 respectively, of medical cover, as some private medical treatments can be quite expensive, but it doesn't include dental or optical claims or cash payments for an NHS hospital stay. The top-up additional medical cover will only be available when all the money in your personal deposit account has been used and will reduce with each claim you make over the ten year period. It is not part of your personal deposit account balance. This amount will be shared with any other family member covered on the policy.

Here's an example: Miss L has been a policy holder for 18 months and her two children are covered on the scheme.

Her fixed premiums are £60 a month and her employer is paying an extra £10 a month for the top-up. She hasn't put any extra money into her personal deposit account, and so far she's made no claims.

So her personal deposit account balance is £260 (£15 x 18).

Her own share of any claim is 10%. Miss L now needs surgery, and the cost of having this done privately is £8,000. Without the top-up, she would be entitled to claim $£260 \times 10 = £2,600$ towards the treatment. £260 from her personal deposit account and £2,340 from us.

However, because her employer is paying the extra £10 a month for the top-up:

- We will use the £260 in Miss L's personal deposit account to pay her 10% share.
- We will pay the £2,340 as our 90% share of £2,600.
- We will pay the other £5,400 (£8,000 - £2,600) from her top-up cover.

So Miss L's surgery bill is paid in full and her £30,000 top-up is now reduced by £5,400 to £24,600.

5. Your healthcare cover in detail

How to apply for cover

Your employer will decide which method of application is most suitable for you, the employee. This will affect you, since these applications are the terms on which the contract is agreed and upon which claims will or will not be paid in the future. Dependants will be covered on the same basis as you. Schemes will consist of a minimum of 3 employees.

The Group Healthcare Deposit Account provides Private Medical Insurance (PMI) benefits. PMI policies provide cover for the cost of private medical treatment for unforeseen medical conditions arising after your policy starts. Your policy is not intended to cover conditions which you already had before your policy started – these are called ‘pre-existing conditions’. Conditions which are related to pre-existing conditions are also not usually covered. A related condition is one that is caused by, or could be the cause of, another condition. Your policy will not cover all medical treatments. This chapter explains what is and isn’t covered.

Your underwriting options

Underwriting is the process by which we decide on what terms we will accept a person for cover, based on the information they supply. The employer has a choice of four ways to apply for a Group Healthcare Deposit Account and can decide which, in their opinion, best suits the employee’s requirements:

■ Full Medical Underwriting

This is based on the employee completing a health questionnaire (also called a Medical History Declaration). If the employer chooses this option, the employee will be asked a number of questions about their health. These will enable us to understand the employee’s medical history. It is important that the employee considers the questions carefully and answer them fully. We will ask if the employee has had any signs or symptoms of a list of medical complaints.

We will review the employee’s details and decide the basis on which we can accept them for cover. If necessary, we may need to ask the employee’s doctor for any further information we need to help us to do this. If the employee has a pre-existing condition that may need treatment in the future, we will usually exclude it from the cover along with any conditions related to it. We will show any exclusions on the policy schedule the employee receives from us when we have processed the application.

If we exclude treatment for a pre-existing condition at the time the employee’s policy starts we will, in some cases, review the exclusion in the future should the employee wish us to do so.

Of course, any new medical conditions arising after the start of the employee’s policy will be covered immediately subject to the policy terms and conditions.

Please note: The employee must ensure that they provide full and accurate information in answer to the questionnaire. Failure to do so may mean that we cannot cover a claim or even that the employee's policy is void. If the employee is unsure whether we would want to know about a particular condition, they should tell us about it. The employer will not see the application form or know of any exclusions.

What is the advantage of Full Medical Underwriting?

Although this option involves more of the employee's time when completing their application, it does mean that, when your employee receives their policy documentation, they will know which pre-existing conditions are excluded from cover.

■ **Moratorium**

With this option the employee does not need to fill in a health statement. Instead, we automatically exclude any pre-existing conditions for which an employee has received treatment and/or medication, or asked advice on, or had signs or symptoms of (whether or not diagnosed), during the five years immediately before the employee's cover started..

However, if you do not have any signs, symptoms, treatment, medication, or advice for those pre-existing conditions, or any directly related conditions, for two continuous years after the employee's policy starts, then we will reinstate cover for those conditions.

The employee should understand that long-term medical conditions, which are likely to continue to need regular or periodic treatment, medication or medical advice, will never be covered by the employee's policy. The employee should not delay seeking medical advice or treatment for a pre-existing condition simply to obtain cover under the policy. Of course, as with full medical underwriting, new medical conditions arising after the start of the employee's policy will be covered immediately subject to the policy terms and conditions.

What is the advantage of moratorium underwriting?

If the employer chooses this option the employee will not be asked to disclose details of medical history, but it relies on the employee to understand that if they have any existing medical conditions these will be excluded from cover. Also, if the employee can satisfy the criteria of two years outlined above for a pre-existing condition, then treatment for that condition will automatically be covered if it recurs, subject to the policy terms and conditions.

If you are switching from another provider. Continued Personal Medical Exclusions (CPME)

If your company has Private Medical Insurance cover with another insurer and wishes to switch to our policy, we will require completion of a short application form or forms in which questions are asked about recent health conditions. We will also need to see a healthcare certificate from your current insurer.

If any medical conditions were not covered (excluded) under your previous policy, these exclusions will continue under our policy. Likewise, if any serious condition is ongoing and requires further treatment soon, we may delay or refuse cover. There are two ways to apply if you are switching provider, both of which are described as CPME in the examples below.

- Individually signed applications – each employee can complete and sign an application.
- Single signature – a Company Secretary or HR representative can sign one form on behalf of all employees, detailing any recent health problems. This form covers schemes of 5-50 employees only.

Questions an employee may ask

Example 1: I had an operation on my right knee recently. Will I be covered for any further treatment on it after my policy starts?

■ Full Medical Underwriting

If the operation was recent, there is a chance that we would exclude future claims relating to your right knee. However, we could put a temporary exclusion on claims for the knee, so as long as there are no problems in the two year period after joining, you can apply to us to have the exclusion removed.

■ Moratorium

If the operation was performed in the five years prior to you taking out the policy you will need to have had a period of two consecutive years after the policy has started where you have not required any treatment, advice or medication for this condition.

■ CPME

Only if there was an exclusion on claims for your right knee under your previous cover with another insurer or if you had treatment planned when you joined, would we not pay for this.

Example 2: Some time after my cover begins, I go to the doctor for a routine visit. A heart condition is diagnosed and it must have started to develop before my cover began. What is the position?

■ Full Medical Underwriting

If the condition was diagnosed after the start of your policy and if you had not had any signs, symptoms, treatment or advice for this condition before your policy started then cover would be available even if it was proved that the condition existed before you took out the policy.

■ Moratorium

If the condition was diagnosed after the start of your policy and if you had not had any signs, symptoms, treatment or advice for this condition in the five years prior to you taking out your policy then cover would be available even if it was proved that the condition existed before you took out the policy.

■ CPME

As your visit was unplanned, we will pay for your treatment.

Example 3: What if I suspect I am suffering from a condition (for example, I have a lump) but have not seen a doctor about it, nor received any firm diagnosis before my cover starts? Will I be covered if I need to have any investigations or treatment for the condition once my policy has started?

■ **Full Medical Underwriting**

If you had a lump, this could reasonably be considered a sign or symptom of a complaint that you should report on your application. As long as you do so, we will let you know before you join whether an exclusion will apply. So you will know before your investigations or treatment whether or not this will be covered.

■ **Moratorium**

As an obvious sign or symptom which existed in the five years prior to taking out the policy investigations or treatment for the lump would not be covered. We would, as usual, take advice from the GP/treatment provider as to whether the lump existed prior to you joining.

■ **CPME**

Only if there was an exclusion on claims for the problem under your previous cover with another insurer, would we not pay for this.

Example 4: How do regular check-ups affect the moratorium?

■ **Moratorium**

If you have a condition before your policy starts and your doctor or specialist recommends that you continue to have regular check-ups for that condition then we will not cover the cost of the consultations or any treatment received for this condition. Cover for this condition will be available once you have had two years where you have not had any signs, symptoms, treatment or advice for this condition.

Medical cover

What's covered

- Acupuncture, alternative medicine and homeopathy from accredited providers.
- Acute medical conditions that are not listed under 'What's not covered' or that are directly linked to any condition on that list.
- Cancer treatment, including chemotherapy, radiotherapy, oncology and cancer surgery.
- Chiropody and podiatry for acute conditions.
- Consultations, diagnosis, pathology and other hospital tests that your GP or other treatment provider has recommended.
- Heart surgery.
- In-patient or day-patient treatment of acute conditions.
- Nursing at home by a qualified nurse, provided this is required as part of your treatment for an acute condition or for treatment of an acute worsening of a chronic condition (maximum 6 weeks per scheme year).
- Operations (including minor ones for ear, nose and throat, carpal tunnel, adenoids and tonsil removal), surgeons' fees, anaesthetic, scans of all types (CT, MRI, etc.), physiotherapy and other manipulative treatments such as chiropractic and osteopathic work by qualified practitioners.
- Oral surgical procedures.
- Private ambulance where medically necessary.
- Pre-authorized consultations and treatment from a specialist for psychiatric conditions we deem to be acute (curable within 6 outpatient consultations).
- Counselling service – see page 21 for further details.

What's not covered

- Any costs in connection with childbirth, fertility testing or infertility treatments, or any treatment to help, prevent or help recover from pregnancy.
- 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).
- Cosmetic treatment or plastic surgery, unless this is medically required, for instance as a result of burns or serious injuries while you are an account holder. This extends to any operation to improve physical characteristics e.g. breast enlargement or reduction, which does not benefit your physical health.
- Out-patient drugs and dressings.

- Gender re-assignment (sex change).
- Health screening in the first 6 months of membership.
- Hormone replacement therapy (HRT).
- Medical appliances, unless these have been inserted or attached as part of a medical procedure.
- Organ transplants and donations.
- Preventative screening and tests for hereditary (inherited) conditions, cervical smears, mammograms, well-person checks, vaccinations, immunisation and musculoskeletal screenings such as those for osteoporosis.
- Renal Dialysis in either chronic or end stage renal failure.
- Residential stays in a hospital, or for convalescence of any kind. We will only pay for short-term stays necessary because of an acute medical condition or injury.
- Routine testing, treatment or any other service from your GP.
- Treatment for any self-inflicted injury (deliberately done to yourself).
- Treatment from a specialist if your GP does not support your claim.
- Treatment such as hydrotherapy and detoxification in health clinics, spas or clinics that promote general health rather than curing specific incapacities.
- Treatments or remedies that the British Medical Association does not recognise.
- Treatments you receive while living or staying overseas.
- Treatments for conditions not medically necessary (e.g. for obesity, contraception etc).

Dental cover

What's covered

- Fillings.
- Extractions.
- Bridges.
- Dentures.
- Crowns.
- Inlays.
- Dental implants.

What's not covered

- Check-ups (unless they are part of the same bill as other covered treatments).
- Any treatment not listed under 'What's covered' above, including cosmetic dental treatments, scale and polish (or other cleaning of teeth or gums), braces and bite guards.
- Claims in the first six months of joining.
- Dental treatment requiring surgical intervention will be paid under the medical allowance, subject to confirmation from our claims team.

Optical cover

What's covered

- New glasses or contact lenses.
- Repairs to glasses.
- Prescription sunglasses.
- Corrective eye treatments by lasering. Other eye operations will be treated as part of your medical cover.
- Eye tests. You can claim for one eye test, either arranged by you or your company, every other year. You will pay 10% of each claim from your personal deposit account. You cannot claim in the first six months of your policy.

Please note: You and any dependants covered can make one optical claim per plan every other year. One claim will be taken to mean one bill on one receipt.

What's not covered

- Claims in the first six months of joining.
- Laser eye treatments in the first twenty-four months.

Counselling service

- You* can call our counselling service provider on **0800 027 7844** (free phone).
- You* should tell them you are with National Friendly and should have the following ready when you call the designated number:
 - Your name and date of birth
 - Your National Friendly reference number and Policy number (these are shown on your policy schedule)
 - Your postcode
- Your* call will be confidential and will be free of charge. We will not ask for any details about it.
- If you* are referred for face to face counselling sessions, you can claim for the cost of these on your policy as part of the medical allowance – you* will pay 10% own share of each claim from your personal deposit account. We will liaise with the counsellor to make sure there are no problems in authorising the counselling sessions available on your policy, which are limited to a maximum of five.

Health screening

- You* can have a health screen, either arranged by yourself* or your employer, to the maximum of £350. The cost of one screening may be claimed every three years. You* cannot claim for this in the first six months of your policy.

*or any covered family member.

NHS hospital stay payments

What's covered

- You* can claim a cash payment for up to ten overnight stays in an NHS hospital each year.

What's not covered

- Claims for NHS hospital stays where you have received treatment for which you are not eligible under the terms of your policy. i.e. pregnancy, pre-existing conditions, treatment of chronic conditions.

*or any covered family member.

Any listed allowances will be per plan and not per member of the plan.

General exclusions

What's not covered

- 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 treating any condition like these.
- Accident and emergency admissions.
- 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 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, parascending, paragliding, mountaineering, and 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 your employee or other insured is paid for).
- Learning difficulties, including dyslexia, development problems, or behavioural problems such as ADHD (attention deficit hyperactivity disorder).
- Treatment of chronic conditions as defined in section 6 on the next page.
- Sexually-transmitted disease or sexual dysfunction.

6. When we will and won't pay out

Your Group Healthcare Deposit Account aims to return you to health when you get a condition that will respond quickly to treatment – whether that involves a major operation or a few physiotherapy sessions. These are known as acute conditions. We will pay out for acute conditions covered by your policy. If an acute condition develops into a chronic condition, we will stop paying the claim. Chronic conditions are diseases, illnesses or injuries that:

- continue indefinitely and have no known cure.
- come back or are likely to come back.
- need ongoing or long-term control or relief of symptoms.
- need you to have specialist rehabilitation or training, or regular tests, check-ups or consultations to monitor the condition over a long time.

We will always write and let you know if, after getting advice from your specialist, we believe that your acute condition has become chronic.

The Healthcare Deposit Account does not cover you for chronic conditions. We do however view cancer differently from other chronic conditions, please see page 27 for full details. When you make a claim, we decide whether the condition you are claiming for is chronic or acute. If we decide, using the medical information available, that the condition is chronic, we will not pay for its treatment.

If however, you have a chronic condition and suddenly develop acute symptoms, we may cover you for treatment to return you to a more controlled state of health.

What does this mean in practice?

The examples over the page assume there is enough money in the account holder's personal deposit account to cover their own share of each claim and/or sufficient top-up is in place to supplement your deposit. All payments are subject to the maximum level of cover chosen.

Conditions

How we would deal with them

Angina and Heart Disease

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

We will pay for investigations leading to the diagnosis of angina.

As this is a chronic condition, following initial stabilisation, we will not pay for any monitoring, medication, or routine follow-ups for this condition.

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

As this is an acute worsening of Alan's chronic condition and the aim of the surgery is curative we would pay for Alan's heart by-pass surgery.

Asthma

Eve has been with National Friendly for five years when she develops breathing difficulties. Her GP refers her to a specialist who arranges 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 that her breathing has been much better, so the specialist suggests she has check-ups every four months.

We will pay for the specialist consultations and tests leading up to the diagnosis of asthma.

As this is a chronic condition, following initial stabilisation, we will not pay for any monitoring, medication, or routine follow-ups for this condition.

Eighteen months later Eve has a bad asthma attack.

As this is an acute worsening of Eve's chronic condition we would pay for the treatment required to return her asthma to a controlled state.

Conditions

How we would deal with them

Diabetes

Deirdre has been with National Friendly 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 she then starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments made to her medication regime, the specialist confirms the condition is now well controlled and explains he would like to see her every four months to review the condition.

We will pay for the specialist consultations and tests leading up to the diagnosis of diabetes and would continue cover until the patient was stabilised.

As this is chronic condition, following initial stabilisation we will not pay for any monitoring, medication or routine follow-ups for this condition.

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

As this is an acute worsening of Deirdre's chronic condition we would pay for the treatment required to return her diabetes to a controlled state.

Hip pain

Bob has been with National Friendly 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.

We will pay for Bob's osteopathy until such time as his hip pain is cured.

Should his condition subsequently be diagnosed as chronic, cover would cease.

Conditions

How we would deal with them

Cancer

Beverley has been with National Friendly for five years when she is diagnosed with breast cancer. Following discussions 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 and are there any limits to the cover?

We will pay for any private consultations, surgery, radiotherapy and chemotherapy until Beverley has reached remission or is cured.

Cara has previously had breast cancer which was 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 treatment and are there any limits to the cover?

This is considered to be a new condition and we would therefore pay for the operation, the radiotherapy and the chemotherapy.

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

- 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 (hopefully years).
- 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?

We will pay for treatment if its aim is curative or to achieve remission. This would include consultations, chemotherapy, radiotherapy and surgery. However if at any stage Monica's consultant confirmed that the aim of her treatment became palliative, cover would cease.

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 hospice care.

7. National Friendly's approach to cancer claims

At National Friendly, we won't treat cancer like other potentially chronic conditions.

We have therefore set out the bills we will cover separately.

In general, we will pay towards any treatment you have from diagnosis until remission or a cure is reached, but you should see the section below entitled 'What we do and don't pay for.'

What you have to remember with any medical treatments you have is that the amount received from us will be determined by two limits. We will never pay more than the annual medical limit of your policy (500 times their monthly premium), and we will never pay more than the amount your personal deposit account will fund, unless the top-up cover available in the first ten years of their account applies.

So, if your own share is 10% and your personal deposit account balance is £1,000, we will not pay more than £10,000 towards your treatment. If your own share is 10%, your account balance is £2,000 but your annual medical limit is £15,000 we will not pay more than £15,000 in any calendar year towards your treatment.

If the top-up applies, there could be up to £60,000 additional cover available, in addition to your annual limit.

It is important, therefore, that you know at the beginning of your treatment what options are available in respect of private treatment. You will need to know how much the treatment could cost in total. We can help you by case management of your treatment. Once you are diagnosed, we will help you by liaising with your treatment providers, whether private or under the NHS. Any family member covered under the plan will be subject to and covered within the same limits.

What we do and do not pay for

We will not pay for preventative treatment, routine testing or screening such as, but not limited to, prophylactic mastectomy (where there is no evidence of disease), preventative vaccines, periodic mammograms or genetic testing.

We will pay for what is known as 'active treatment'. This is defined by cancer backup as "treatment intended to affect the growth of the cancer by shrinking the cancer, stabilising it or slowing the spread of the disease and not given solely to relieve symptoms."

If you are being investigated for cancer or have been diagnosed with cancer we will pay for your consultations, surgery, chemotherapy and/or radiotherapy. We will also pay for any scans and tests required to monitor your condition during active treatment of your cancer or to diagnose your cancer, unless done as part of a screening programme or routine testing. In addition we will pay for consultations, scans and tests for a period of two years following successful treatment or during a period of remission.

We will also consider pre-licensed hormonal treatments* recommended by your oncologist as being suitable in your case.

*We will pay for any drug pre-licensed by the EMEA or the MHRA and recommended by your attending doctor/oncologist, but not for clinical trials or experimental treatment not licensed by the above bodies.

Please be aware that some of these treatments are extremely expensive. You should consider your annual benefit limits and the level of premium and build up your personal deposit account if you want this type of cover.

We will pay for bills incurred in hospital or at home. Hospice care is not covered. Dependants covered under this plan will be entitled to the cover listed.

8. How to claim

We're here to help

Always call our Claims Helpline first on **0808 168 2912** to check that your condition and any potential treatments are covered. Our trained staff will make everything as easy as possible for you throughout the process.

Plus we'll always try to make sure the price of your treatment is fair and reasonable and falls within a nationally recognised price band.

How to claim for medical cover

We will ask your doctor to submit a copy of your referral and so will need your permission to view his/her comments, plus those of any attending practitioner. We will send you the medical consent form to enable us to discuss your claim.

A copy of our medical consent form is also available on our website www.nationalfriendly.co.uk/healthcare

The Process

Claims start with a visit to your doctor (GP).

1. When your GP makes a referral, you should let him/her know that you have a policy with us, and ask for the name of a private consultant or treatment provider as an alternative to the NHS.
2. After being referred by your GP, call us to check you are covered. If you don't let us know about your treatment and we don't authorise it in advance, you may well have to pay the bill yourself. Once we have confirmed you are covered, we may ask you to complete a medical consent form so we can speak direct with your GP or treatment provider to get details of your treatment and how your condition came about.
3. Your GP will most likely give you the name of a private specialist. If not, we will let you have 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 the specialist or provider you want.
4. We will check against your application.

5. We will keep you informed about our discussions with your treatment provider and will authorise payment to them. Please help us by informing them you have cover with us and that we and not you will pay for treatment (unless there is any shortfall which we would tell you about well in advance).
6. We will always try to pay your medical provider direct, upon receipt of their original invoice and without your involvement.
7. If, for any reason, the treatment provider sends the bill to you in error, please forward it to us as soon as possible to avoid penalties for late payment.

Multiple treatment claims (physio, chiropractic etc)

If you are likely to need multiple visits to your treatment provider (physiotherapy, chiropractic etc), first call us to check you're covered – you should get a GP referral before each course of treatment.

Once we have given you the go ahead on the claim, and if your treatment provider is happy to do so, we will normally settle your bill at the end of your treatment. You won't need to contact us for each session of treatment but we may check with your provider after eight sessions. This is to establish what extra treatment may be necessary to cure you and to ensure that your future needs can be met.

How to claim for dental or optical cover

You probably won't know before how much the bill is going to be, so you'll need to pay the dentist or optician yourself and then claim the cost back from us. You need to ask our dentist or optician to give you an itemised bill to send in with your claim form.

We will then pay you within five working days.

1. Check you are covered before your appointment.
2. Complete the dental or optical claim form and return it with the itemised bill.

How to claim for health screening

You should call us ahead of the screening to check you are covered. Once we are satisfied you can get the screening done we will liaise with your screening provider to pay the bill direct. If you are unwilling to do so, or the allowance we give will not cover the full cost, you may have to pay the initial bill and claim money back from us. You cannot claim in the first six months of membership.

Using the counselling helpline

You should call the designated number **0800 027 7844**. The call will be free as part of your membership. If the counsellor decides you would benefit from face to face counselling sessions, you will pay a 10% share of the cost of these as you would with any other medical claim. We will pay for up to five sessions in total.

How to claim payments for an NHS overnight hospital stay

If you are admitted to an NHS hospital, please get an admission and discharge sheet signed by a doctor or senior nurse. You'll need to send this to us with the completed claim form.

1. Check cover before you stay.
2. Complete the patient's section of the NHS overnight stay claim form.
3. Ask the hospital to complete their section of the form.
4. Return the form so we can arrange payment.

The above processes also apply to any covered dependants.

9. Extra information

Further information

If you are in any doubt about the suitability of this Group Healthcare Deposit Account, you can call us on **0808 168 7775** and we'll put you in touch with one of our group healthcare consultants. Alternatively you can contact the employer's Healthcare Intermediary.

Payment options

Payments should be made by Direct Debit.

Nominations

You have the right to nominate one or more people to receive the combined value of your National Friendly policies if you die. This is currently limited to a total of £5,000 and would be paid outside the terms of your will or estate. The sum payable on death does form part of your estate for inheritance tax purposes and we will need to see the death certificate and policy schedule for it to be claimed.

Any amount over £5,000 will be paid out according to the terms of your will or estate, once we've received proof of title from the executors or administrators.

For more information, please call us on **0808 168 7775**.

What if you decide you don't want this cover any longer?

If you decide to remove yourself from the Group Healthcare Deposit Account scheme you should inform the person at the company who's running the scheme. Once we have a signed declaration from you, we will close the personal deposit account, end all cover, and return any cash in the account to the employer, though if you have paid money in, your money will be considered to remain and can be returned.

Cover will also end for any covered dependants.

What happens if I leave my current employment or reach 70?

If you leave, either to take a new job or upon retirement or when you reach age 70, you can transfer your cover to an Individual Healthcare Deposit Account. All money in your existing personal deposit account, which has been paid in by your employer, will go back to your employer.

There are a few minor changes involved in doing so, and these will be explained in full at the time. You will be in charge of your own personal deposit account balance and can make cash withdrawals. You must advise us of your choice within three months of leaving the Group scheme.

For more information on the above, please call us on **0800 195 9245**.

What if the employer cancels the scheme?

If this happens, you will not be deemed responsible for closing the scheme and will have the opportunity of continuing to pay your own premium on an Individual Membership plan.

Notice period

You must advise us of your choice of whether or not to take an Individual plan within three months of leaving the Group scheme.

If the account holder dies

We will need to receive a copy of the death certificate from the employer or a dependant. We will then pay the employer any residual deposit account, minus any charges. Any remaining money paid in by the employee will go to a beneficiary. If the account holder dies then cover for any dependants will cease unless they are switching to an individual plan.

If we lose contact with the employee

If we lose contact with a personal deposit account holder or do not hear from the representatives of a policy holder who has died, we will move that person's personal deposit account balance to a holding account where it will earn a rate of interest determined by us. The policy holder or their representatives can claim the money once they give us proof that they are entitled to it.

Transferring or assigning a Group Healthcare Deposit Account

This Group Healthcare Deposit Account is a legal contract between us and the employer and is for the benefit of employees. You cannot transfer it or give it to anyone else.

Tax implications – P11D benefits

The premiums and any other payments of this scheme paid by your employer will be assessed as a benefit in kind if you are earning £8,500 pa or more, including all expenses and before deductions.

In case you have a complaint

We are a mutual association that exists to support our customers and we aim to provide the highest standards of service. If we fall short at any time and you wish to make a complaint, please contact us on:

- **0808 168 7775** (8am–6pm weekdays)
- Email compliance@nationalfriendly.co.uk
- Fax 0117 980 9358
- Or write to Compliance Department, National Friendly, 4–5 Worcester Road, Clifton, Bristol BS8 3JL.

A copy of our complaints procedure is available on request or from www.nationalfriendly.co.uk

If you make a complaint and are dissatisfied with our response, you may be able to ask the Financial Ombudsman Service for an independent review:

- Financial Ombudsman Service, South Quay Plaza, 183 Marsh Wall, London E14 9SR.
- Telephone 0845 080 1800
- E-mail complaint.info@financial-ombudsman.org.uk
- Website www.financial-ombudsman.org.uk

Please remember the Ombudsman Service cannot deal with your complaint until you have first raised it with us. In making any complaint, your right to take legal proceedings is not affected.

Our right to cancel your policy

We have the right to expel anyone named on this scheme or plan in connection with this or any other National Friendly policy if they:

- Provided false information with the aim of gaining money from us.
- Not acted in a fair and reasonable way.

If we plan to expel a policy holder, we will first explain what will happen and their right to appeal. If a policy holder is expelled, we may end their policy at any date after that. We will return all money, less any money obtained fraudulently and all reasonable expenses incurred in expelling the member.

Applicable law

If there is a legal dispute, English law will apply.

Language and currency

All correspondence will be in English and all currency will be £ sterling.

All literature is available in Braille, large print or audio.

To request a copy please call us on **0800 195 9245** (8am–6pm weekdays).

Alterations to the policy terms

These terms and conditions may change as a result of a new law or regulation. We also have the right to change the terms and conditions at any time as a result of product or system development, or changes in the cost of providing a service or product to you, or to remove any ambiguities. We will write to you and let you know of any changes. If you do not accept the changes then your policy will be cancelled.

Words and phrases explained

Accident or Emergency Treatment

If your employee* needs to go to hospital immediately because they're suffering acute symptoms from an illness or accident, or if your employee* goes 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 your employee* to the state of health they were in before or which leads to your employee's 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.
- Your employee* needs to be rehabilitated or specially trained to cope with it.
- It needs long-term monitoring through consultations, check-ups, examinations or tests.

Consultation

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

Day-patient treatment

Treatment for which your employee has to go into a hospital or day-patient clinic/unit because they need time to recover under medical supervision, but for which they do not need to stay overnight.

Dependant/family member

Dependant or family member will only be covered if agreed in writing by the employer and National Friendly.

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.

EMEA

The European Medicines Agency.

Fixed monthly premium

Monthly premium of which 25% goes into a personal deposit account. The premium is fixed for 5 years.

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.

Group Healthcare Deposit Account

The healthcare policy the employer has bought by signing our group application form and agreeing the terms of your employee's* policy schedule and these terms and conditions.

Hospital

- A private hospital in the UK which is registered in accordance with UK law and which has specialist facilities for major surgical operations.
- An NHS pay-bed. This is a bed and treatment in an NHS hospital that an employee* pays for.
- Any hospital or establishment that we agree is appropriate for providing treatment.

Hospital charges

Charges for accommodation, nursing care, drugs and dressings, diagnostic tests, prosthesis and operating costs.

In-patient treatment

Treatment which, for medical reasons, means your employee* has 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 your employee* knew about when they 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 your employee* has difficulty getting to in-patient or out-patient appointments, he/she may need to get treatment at home. Your employee* is covered to receive treatment at home by a qualified nurse.

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 your employee does not go in for day-patient or in-patient treatment.

Own share

Your employee's set percentage paid towards each claim from your employee's* personal deposit account.

Personal Deposit Account

Your employee's own account that 25% of your fixed monthly premium goes into.

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 details of the Group Healthcare Deposit Account. We will give your employee their policy schedule when they join, and we will update it whenever your employee's* account or other details change. The employer will also receive a policy schedule for the Group.

Pre-existing condition

Any disease, illness or injury that an employee* has had medication, advice or treatment for, or that has produced symptoms, whether or not it was diagnosed, in the five years before joining this Group Healthcare Deposit Account.

Private 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 plan this means England, Scotland, Wales, Northern Ireland, the Channel Islands and the Isle of Man.

*or a covered dependant.

NOTES

NOTES

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