Your Health Fund

Diagnosis Plus Plan - Policy Summary

Contents

Introduction

This is an important document which you should read before deciding whether to apply for the Diagnosis Plus Plan. It provides a summary of the cover provided by the policy and how we deal with claims, to help you decide if the Diagnosis Plus Plan is right for you. Full details of the policy benefits and exclusions are provided in the Terms and Conditions and Policy Schedule which we provide to you once you have taken out the policy. A copy of the Terms and Conditions can be obtained on request before you take out the policy.

The Diagnosis Plus Plan is an insurance policy which provides access to faster diagnosis of medical conditions via private healthcare services.

As with all insurance products, we recommend you review and update your cover periodically to ensure it remains adequate for your needs.

The Diagnosis Plus Plan is provided by National Friendly, a trading name of National Deposit Friendly Society Ltd.

1. Diagnosis Plus Plan cover

What's covered

The Diagnosis Plus Plan provides funding for consultations, diagnosis and a range of out-patient treatments. This is a summary of the cover available provided by the policy. Full details will be provided in your policy Terms and Conditions document.

What's covered under the Diagnosis Plus Plan	
Benefit	**Limitations of cover**
Private GP consultations which lead to a referral to a specialist.	
Private GP consultations which do not lead to a referral to a specialist.	We will pay for only one visit to a private GP per policy year (which does not lead to a referral to a specialist) and up to a maximum cost of £100.
Diagnostic consultations with a specialist.	
Diagnostic tests to find or help find the cause of your symptoms, including: ■ a range of camera-based investigations such as colonoscopies and endoscopies; ■ angiograms; ■ biopsies; ■ ECGs; ■ pathology tests; ■ scans (including MRI, PET, CT); ■ x-rays.	We do not pay for arthroscopes.
The following therapies before treatment of a medical condition: 1. acupuncture; 2. chiropractic treatment; 3. osteopathy; 4. physiotherapy.	We do not pay for alternative therapies.
The following therapies for the feet and lower limbs: 1. chiropody to treat medical conditions; 2. gait assessment; 3. podiatry to treat medical conditions.	We do not pay for non-medical treatments such as fungal treatments, nail clipping and cleansing of the feet. We do not pay for insoles, hosiery or footwear of any type.

What's covered under the Diagnosis Plus Plan	
Benefit	**Limitations of cover**
Minor surgery for the following out-patient treatments where medically necessary: 1. carpal tunnel decompression; 2. excision and cauterisation of cancerous tissue; 3. joint injections for tendonitis and bursitis.	We do not pay for these treatments for cosmetic reasons or any other circumstances.
Mental health cover: 1. one initial psychiatric assessment per policy year, carried out on an out-patient basis; and 2. up to 10 face-to-face sessions per policy year with a counsellor or psychotherapist.	We do not pay for any subsequent psychiatric treatment.
Heart cover for the following: 1. angiograms; 2. angioplasty performed immediately after an angiogram; 3. biopsies; 4. blood tests; 5. ECGs.	We do not pay for planned angioplasty which is arranged by appointment.
Cancer cover for the following: 1. biopsies; 2. blood tests; 3. scans; 4. x-rays. required to diagnose your condition prior to active treatment.	We do not pay for: 1. genetic testing; 2. preventative treatments prior to diagnosis; 3. out-patient treatments; 4. screening.

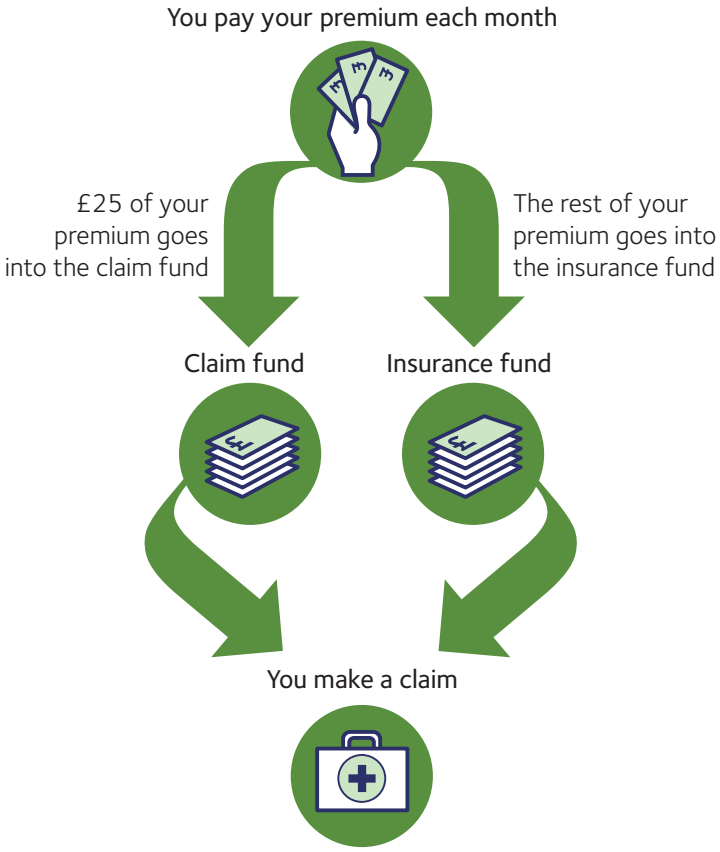
How much you can claim

Eligible claims will be covered:

1. within the limits provided by your claim fund, and
2. provided they don't exceed the financial limits specified in our Schedule of Fees, which is published on our website and can be provided on request.

The claim fund

The Diagnosis Plus Plan will cover eligible claims up to five times the value of your claim fund. To start you off we will add a notional £100 to the claim fund, providing £500 worth of cover on day one of your policy. Each time you pay a monthly premium we put £25 into your claim fund, building up your level of cover until you need to claim.



- Eligible claims are covered up to five times the amount in the claim fund.
- One-fifth (20%) of the claim cost is taken from the claim fund, with the remaining four-fifths (80%) from the insurance fund.

You can withdraw the remaining balance of your claim fund, although you won't be able to withdraw the notional £100 added at the start of your policy.

What's not covered

This is a summary of the general exclusions from cover. Full details will be provided in your policy Terms and Conditions document.

1. accident and emergency;
2. addiction;
3. age-related medical conditions;
4. AIDS/HIV;
5. allergies;
6. chronic conditions;
7. congenital conditions;
8. corrective treatment;
9. criminal activity and public order offences;
10. developmental/behavioural conditions;
11. dialysis;
12. elective treatment;
13. epidemics;
14. experimental treatment;
15. fertility treatment;
16. natural disasters;
17. pre-existing conditions;
18. preventive treatment;
19. rehabilitation, residence and recovery;
20. routine monitoring, tests and examinations;
21. screening;
22. self-inflicted injury or self-harm;
23. sex change;
24. sexual health;
25. sleep disorders;
26. social and domestic care;
27. spa therapies;
28. sports and pastimes;
29. transplant operations;
30. treatment on a cruise ship;
31. treatment received overseas;
32. war, terrorist acts and civil commotion;
33. weight loss treatment and obesity treatment.

Where you can go for consultations and tests

We do not specify which consultant or specialist you need to see, as long as the costs fall within the financial limits detailed in our Schedule of Fees. This is available to view on our website or can be provided on request. Consultants and specialists will also need to meet certain criteria in terms of their qualifications and registrations in their field of expertise.

We do not pay for consultations or tests at the following hospitals:

- Cromwell Hospital, London;
- The London Clinic;
- Hospital of St. John and St. Elizabeth, London;
- Harley Street at UCH, London;
- Harley Street Clinic, London;
- King Edward VII's Hospital – Sister Agnes, London;
- Lister Hospital, London;
- London Bridge Hospital, London;
- Portland Hospital for Women and Children, London;
- Princess Grace Hospital, London;
- Wellington Hospital, London.

We will always endeavour to give you as wide a choice as possible. We may update the list of hospitals from time to time. Please see our website for the most up-to-date list or ask us for details.

2. How the policy works

The policy term

The Diagnosis Plus Plan runs for a five-year term.

Premiums and premium reviews

Your monthly premiums

Premiums are payable by monthly Direct Debit and include Insurance Premium Tax at the current rate. Should the rate of Insurance Premium Tax change we will update your premium to reflect this.

It is important that you keep your premium payments up to date to maintain cover under your policy. If you don't you won't be able to claim and your policy will be closed after three months.

Where we offer a discount on your premium we will show this on your quote and Policy Schedule.

Annual premium reviews

Premiums will be reviewed each year until the end of the policy term and will take into account:

- your age;
- the expected costs of providing cover to you, including medical claim cost inflation and tax;
- the claims that have been made on all policies with terms similar to yours.

The annual premium review could result in your premium rising, falling or staying the same. Any changes to your premium as a result of the premium review will take effect on each anniversary of your policy. We will write to you in good time before any changes are made to your Direct Debit.

Applying for a policy

Who can apply

You can apply for the Diagnosis Plus Plan if you are:

- between the ages of 18-75. A parent or guardian over the age of 18 can also apply for a policy on behalf of a child; and
- a permanent resident of the United Kingdom (excluding the Channel Islands and the Isle of Man)

Our approach to claims

Our aim is to make the claims process easy and straightforward. When you want to make a claim simply call us for authorisation using the details on the back page of this document. We'll explain what you can claim for and be on hand to answer any questions you have and guide you on your options throughout your claim. Full details of how to claim will be included in your policy Terms and Conditions document.

For eligible claims relating to diagnostic consultations and out-patient treatment you will need a referral from an NHS or private GP. For eligible claims relating to chiropractors, physiotherapists and mental health services you do not need to obtain a referral from your GP.

Where we need confirmation or evidence to support your claim we will ask you for permission to obtain this from your GP, specialist or treatment provider.

Your choice of application

There are three ways you can apply.

1. Full medical underwriting

This might be suitable for someone who wants clarity on whether a pre-existing condition will be covered. We will tell you if a pre-existing condition is excluded from cover.

On your application form you provide us with details of medical conditions which you have been aware of, or had signs or symptoms of, or undergone consultations, investigations, medication, advice or treatment for, in the last five years. We will tell you whether we are prepared to offer you cover for those conditions. You can then choose whether to accept cover on that basis. Your Policy Schedule will specify which conditions are not covered (excluded) or which are covered only to a limited extent.

2. Moratorium

This might be suitable for someone who has not had signs and symptoms of a pre-existing medical condition in the last five years before applying for the policy.

On your application you do not provide us with any details of your medical history. Any medical conditions which you have been aware of, or had, signs or symptoms of, or undergone consultations, investigations, medication, monitoring, advice or treatment for, in the last five years will not be covered for at least the first two years of the policy. If you do not have any signs or symptoms of a pre-existing medical condition in any two year period of the policy then any cover for that condition will be provided in line with the terms and conditions of this policy, from that point on.

3. Continued personal medical exclusions

This application might be suitable for someone who:

- is applying to carry forward existing exclusions from a current private medical insurance policy to the Diagnosis Plus Plan; and
- wants clarity on whether a pre-existing medical condition will be covered under the In-patient Plan.

On your application you will provide us with some details about your medical conditions for which you have received treatment, or had, or may be planning to have, a specialist consultation, in the last two years. We will ask you to provide your most recent private medical insurance schedule or certificate as evidence of your existing cover.

If any medical conditions are not covered (excluded) under your current policy these exclusions will continue under the Diagnosis Plus Plan. We will also tell you whether we are prepared to offer you cover for any pre-existing medical conditions. You can then choose whether to accept cover on that basis. Your policy schedule will specify which conditions are not covered (excluded) or which are covered only to a limited extent.

3. Your information and rights

Your right to change your mind

You can cancel your policy within 14 days of receiving your policy documents. A cancellation notice will be included with your policy documents, to use if you wish to change your mind and cancel your policy. You will receive a full refund of any premium paid, provided you have not made a claim in that time.

What happens when your policy ends

At the end of the five year term your policy will end. There is no automatic renewal. We will let you know your options for renewal and, should you wish, you can apply for a further policy. You can re-apply for further cover at the end of the five year term even if you are over 75.

Your application will be subject to fresh underwriting based on your claims history as a policyholder of a Diagnosis Plus Plan and your health at the time of renewal. We may be able to offer a policy with exclusions for any medical conditions that you have claimed for or, as an alternative, may offer renewal with an increase to standard rate premiums.

When the policy ends, either because it has reached the end of the term or because you cancel it earlier, if you have a claim in progress we will explain how any outstanding claim costs will be settled. You will not receive a refund of premiums paid where you cancel after 14 days.

We will return any claim fund balance due once all outstanding invoices have been received and paid.

How to make a complaint

We always do our best to provide a high standard of customer care, but if something goes wrong please tells us so we can put it right. You can contact us using the details below. We will give you a copy of our leaflet 'How to make a complaint' explaining how we deal with complaints. This leaflet is also available at any time to view or download from our website.

Telephone:
0333 014 6244 Calls from UK landlines and mobiles cost no more than a call to an 01 or 02 number and will count towards any inclusive minutes.
8am-6pm Monday to Friday. Calls are recorded for training and quality purposes.

Email:
complaints@nationalfriendly.co.uk

Post:
Customer Services Manager
National Friendly
11-12 Queen Square
Bristol
BS1 4NT

We will investigate your complaint and try to resolve it promptly to your satisfaction. We aim to resolve complaints and send you our final response in writing as quickly as possible, or within eight weeks.

If you are not satisfied with our final response you may have the right to take your complaint to the Financial Ombudsman Service. This service is free and using it in no way affects your legal rights.

You can find more information on their website www.financial-ombudsman.org.uk

Our regulators

National Friendly is the trading name of National Deposit Friendly Society Ltd which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Our financial services register number is 110008.

You can check this at: https://register.fca.org.uk

The Financial Services Compensation Scheme (FSCS)

You are covered by the FSCS and may be entitled to claim compensation from them if we cannot meet our liabilities. Details can be found on their website www.fscs.org.uk

Alternative formats

All literature can be made available in Braille, large print or audio. To request a copy, please contact us using the details on the back page of this document.

Contact information

For information on setting up this policy please contact your healthcare intermediary. Alternatively you can call us on:

0333 014 6244 Calls from UK landlines and mobiles cost no more than a call to an 01 or 02 number and will count towards any inclusive minutes. Lines are open 8am-6pm Monday to Friday excluding bank holidays. Calls are recorded for training and quality purposes.

Or email us on:
info@nationalfriendly.co.uk

Or visit us at:
www.nationalfriendly.co.uk

Or mail us at:
11-12 Queen Square, Bristol BS1 4NT

National friendly

YHF DPPS 05.17