National friendly

Your policy explained

Group Healthcare Deposit Account

Your revised policy terms and conditions from 1st May 2012

In this guide

These are the terms and conditions of your policy and should be read to understand how your policy works. It is the responsibility of the employer and employee to let us know if any personal details of a policy change.

This document replaces the Your Policy Explained document you received on joining.

It contains updated information applicable from 1st May 2012.

1. Your Group Healthcare Deposit Account

Reference to *'plan'* or *'policy'* in this document refers to the cover afforded to you as an employee. Reference to *'scheme'* will mean the group cover purchased by your employer. Reference to *'member'* means your membership of National Friendly.

The policy is available to you (and your dependants if permitted by your employer) until the retirement age which will be age 65 or age 70 (as detailed on your policy schedule) 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 at which point their cover will end.

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 during the period of employment.

Responsibility of the employee

- To make a decision (within 2 months) of leaving employment as to whether to continue with an individual policy or terminate the policy. See page 28 for further details.
- To notify us as soon as your name or address is to change.
- To be responsible for the conduct of any dependant on the plan.

The policy

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

Basic workings

Your employer agrees to pay a monthly premium for your policy while you are their employee. Part of that money goes into a deposit balance to pay a share of any claim you may make.

Your deposit balance is used to fund future claims. When you leave your employment you may be able to take an individual policy and continue to make payments yourself – see 'What happens if I leave...'on page 27 for further details.

As an employee:

- You need to understand that a 35% share of each claim will come from your deposit balance.
- A top-up allowance will supplement medical claims in the first 10 years of the policy.
- You will have the option of paying your premium in the event your employer is unable to do so.
- You will be responsible for making sure a valid claim is paid if we cannot pay the treatment provider directly (this will be refunded to you).
- You cannot withdraw any money 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

Fixed monthly premium

Your employer will pay regular premiums. The amount paid each month will depend on the level of healthcare cover chosen.

We won't increase the monthly premium for any member of the Group, no matter how many claims an employee makes or how old they become. This table shows how much different levels of cover cost. Premiums here show those available for schemes taken out on or after August 2009 for new entrants. Your own premiums and cover will be detailed on your policy schedule.

	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

**See "Covering an employee's dependants" page 5. All premiums inclusive of Insurance Premium Tax at the current rate.

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 deposit balance at the time of claim, since that balance will fund 35% of the claim. Own share rates can change please see page 7.
- Only one optical claim can be made on the plan every other year. See Optical cover p14 for details.
- You* can claim a maximum of 10 NHS hospital overnight stays each calendar year (pp15-16).
- You* can claim an additional £350 for Health Screening. See page 15 for further details.

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

Minimum monthly payments

These will be based on your age on joining. These are minimum premiums only – your employer will decide on your actual premiums. The maximum premium per employee 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

Covering an employee's dependants

If your employer chose at outset 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 if these are still on sale.

Top-up premium

For added cover in the first ten years, your employer will pay an extra early years top-up premium of either £10 or £15 a month. This gives each employee an extra £30,000 or £45,000 respectively of medical cover in case there is not enough money in your deposit balance to pay your share of a claim. This will be shared with any dependants on a plan. See page 8 for further details.

Please note: None of this top-up premium goes into your deposit balance. 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 covered dependants based on your ability to fund 35% of the claim from your deposit balance. Each employee and covered dependants will also claim from one top-up allowance per plan.

Changing the premium to change the level of cover

Your employer can increase the monthly premiums for each employee by £10 each year without additional underwriting. For a couple the permitted increase is £20 a month without underwriting as in the multiples shown above. If a higher increase in cover/premium payments is required we will 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 plan under the Group scheme 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 employer's scheme and your plan under it will automatically close and you will not be able to re-open it. If your policy under that scheme is closed in such circumstances, we will write and tell you and your employer. You can withdraw any money to which you are entitled under the scheme within 28 days, or we will move it to a holding account. We will obviously correspond with your employer as soon as any payment is missed. We will let you know in the event that non-payment is not corrected and your cover is under threat.

3. Your deposit balance

How your deposit balance works

Your fixed monthly premiums are divided into two parts. Half helps fund the cost of this healthcare scheme. The other half goes into your deposit balance. So if your employer decides on a fixed monthly premium of, say £40, you will be building your deposit balance by £20 a month. When you need to claim, provided your deposit balance will pay 35% of the cost, we'll pay the rest. The more money you have in your deposit balance, the more of your chosen level of cover you'll be able to claim. Any money used from your deposit balance to pay your share of a claim will show as a deduction on your annual statement. Please also refer to "Your top-up" on page 8 for details of how your cover is supplemented.

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

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 deposit balance. 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 help you to claim the maximum level of cover if you need to. The employer and employee can call us on 0808 168 7775 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.

Please note: The employer or the employee can make deposits at any time, but we will not be able to use any additional lump sum deposits to cover a claim for a complaint you knew, or could reasonably have expected to know 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.

Ownership of the deposit balance

If you joined before August 2009 as an employee you will receive the deposit balance if you leave the company. If your company scheme started after August 2009 your employer will receive any balance in deposit that they have paid in.

Withdrawing cash from your deposit balance

Your employer cannot withdraw cash from your balance whilst you are still part of the scheme. You won't be able to withdraw any cash from the policy which your employer has paid. You can only withdraw from the remaining balance of money you have paid in. However, you should also read 'What happens if I leave my current employment or reach the maximum age?'- see page 27.

Helping you keep track of your deposit balance

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 available for claims.

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 deposit balance to fund 35% 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. If a claim is paid in part by another source we will pay our proper share in accordance with the terms and conditions.

Your level of cover

Please see the table on page 4 to check the maximum level of cover available for the chosen monthly payment.

Your own share of each claim

Your deposit balance will pay a set 35% share of each claim.

The 35% share is not necessarily fixed forever and we reserve the right to change it up or down. However, we will only increase it in exceptional circumstances, for example if there are unusually heavy claims across the whole of the Group Healthcare Deposit Account policy base.

Here's a tip: To find out how much you can claim based on how much you have in your deposit balance, divide your current balance by 35%.

E.g. If Ms R has a balance of £200 in her deposit balance, she divides this by 35%..
£200 ÷ 35% = 571.43, so she can claim a maximum of £571.43.

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

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

In this case we will offer to 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 £1,000. Her own share of the claim is 35%, which is £350. But she only has £200 in her personal deposit balance.

Because she only has £200, her 35% share will only allow her to claim a maximum of £571.43. So we make Ms C a pro rata offer of £571.43. £200 will come from her balance as her 35% share and we will pay the other 65% of £371.43, making £571.43 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 £428.57 from elsewhere before incurring the cost.

This example assumes that Ms C no longer has the top-up cover - See page 8.

Your top-up

For an extra £10 or £15 a month for the first ten years each employee will get what we call the top-up. It gives you an extra £30,000 or £45,000 respectively of medical cover, but it doesn't pay towards 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 which can be used from your deposit balance has been used and will reduce with each claim you make against the top-up over the ten year period. It is not part of your deposit balance. This amount will be shared with any other family member covered on the plan. The additional medical cover will end after the first ten years or when the chosen top-up is used up through claims, whichever is sooner. At this point you should ensure your deposit balance has enough to cover your own share of any claims you think you might have to make in the future.Your employer will choose which top-up premium they wish to pay prior to the policy starting.

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 deposit balance, and so far she's made no claims.

So her deposit balance is £540 (£30 x 18).

Her own share of any claim is 35%. 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 £540 ÷ 35% = £1542.86 towards the treatment. £540 from her deposit balance and £1002.86 from us.

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

- We will use the £540 in Miss L's deposit balance to provide £1542.86 in cover.
- We will pay the £1002.86 as our 65% share of £1542.86.
- We will pay the other £6457.14 (£8,000 - £1542.86) 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 £6457.14 to £23,542.86.

5. Your healthcare cover in detail

How to apply for cover

Your employer will decide which method of application is used for new joiners. 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.

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 three ways to apply for a Group Healthcare Deposit Account and decides which to use.

- **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 answers 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 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 will not 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 an 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 no signs or symptoms recur, and no treatment, medication or advice is sought 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 their 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 scheme, we will ask the employee to complete a short application form in which questions are asked about recent health conditions.

If any medical conditions were not covered (excluded) under your previous policy, these exclusions will continue under your policy with us. Likewise, if any serious condition is ongoing and requires further treatment soon, we may delay or refuse cover.

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.

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 per condition from a psychiatric 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.
- Counselling service – see page 15 for further details.
- Health screening – see page 15 for further details.

Medical Cover: Excluded

- Accident and emergency admission and treatment – see General Exclusions
- 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).
- Health screening in the first 6 months of membership.
- 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.
- 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.

You will pay 35% of each dental and optical claim from your deposit balance. You cannot claim in the first six months of your policy.

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.
- Eye tests (see Glossary). You can claim for one eye test, either arranged by you or the company, every other year.

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.

Optical Cover: Excluded

- Any item or treatment not shown on the 'Included' list on P14.
- Laser eye treatment in the first 24 months.
- Goggles or other protective eyewear designed for work or sports usage.
- Eye operations under general anaesthetic will be treated as part of your medical cover.

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 35% own share of each claim from your personal deposit balance.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. You will pay an own share of 35% of each claim.

NHS payments: Included

- Claims for NHS benefits are not subject to an own share contribution from your personal deposit balance.
- 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, whilst we do not pay for the first night's stay, claims from the second night's stay will be eligible through an accident and emergency admission.

*or a covered dependant

- If you have a child policy, you and your child can claim when you need to stay with your child 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.

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.

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 admission or resultant treatments - please refer to the glossary for a definition of accident and emergency and its implications for cover. You should also see our section on NHS hospital stay payments on page 15.
- 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, parascending, 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.

6. When we do/don't pay for certain conditions

Acute/Chronic conditions explained

What is an acute condition?

The Group Healthcare Deposit Account aims to return you or any covered dependants 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 won't pay for chronic conditions.

What is a chronic condition?

The Group Healthcare Deposit Account does not cover chronic conditions, which 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.

What does this mean in practice?

We will use the information we gather for your claim to determine whether the condition you or any covered dependant is suffering from is chronic (long term and with no likely cure) or acute (curable with treatment). If we decide, using the medical information available, that the condition is chronic, we will not pay for the treatment.

What if your condition gets worse?

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

If you are claiming for an acute condition that then develops into a chronic condition, we will stop paying this claim. We will always write and let you know if, after getting advice from a specialist, we believe that your acute condition has become chronic.

Here are some case studies that show what's likely to be covered and what's not for chronic conditions.

Please note: These examples assume there is enough money in your deposit balance to cover your own share of each claim.

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. All payments will be subject to the maximum level of cover Alan has chosen and how much he has in his deposit balance to pay his own share. 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. All payments will be subject to the maximum level of cover Alan has chosen and how much he has in his deposit balance to pay his own share.
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. All payments will be subject to the maximum level of cover Eve has chosen and how much she has in her deposit balance to pay her own share. 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. All payments will be subject to the maximum level of cover Eve has chosen and how much she has in her deposit balance to pay her own share.

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. All payments will be subject to the maximum level of cover Deirdre has chosen and how much she has in her deposit balance to pay her own share.
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. All payments will be subject to the maximum level of cover Deirdre has chosen and how much she has in her deposit balance to pay her own share.
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. All payments will be subject to the maximum level of cover Bob has chosen and how much he has in his deposit balance to pay his own share. 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. All payments will be subject to the maximum level of cover Beverley has chosen and how much she has in her deposit balance to pay her own share.
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. All payments will be subject to the maximum level of cover Cara has chosen and how much she has in her deposit balance to pay her own share.
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. All payments will be subject to the maximum level of cover Monica has chosen and how much she has in her deposit balance to pay her own share.
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 your monthly premium), and we will never pay more than the amount your deposit balance will fund, unless the top-up cover available in the first ten years of their policy applies.

So, if your own share is 35% and your deposit balance is £1,000, we will not pay more than £2857.14 towards your treatment. If your own share is 35%, your deposit balance is £6,000 but your annual medical limit is £15,000 we will not pay more than £15,000 in any calendar year towards your treatment, even though your balance would have provided £17,142.86.

If the top-up applies, there could be up to £45,000 additional cover available, but only if your claim is within the first ten years of your policy.

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 deposit balance 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 make a claim

Important: All claims must be pre-authorised by our claims team before treatment commences. Failure to do so will mean your claim is declined and you will need to pay for the treatment received.

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 you will have to pay the extra yourself. If you have any kind of shortfall through lack of available cover, you will also 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.

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 Accident and Emergency (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.

- 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 will include 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.

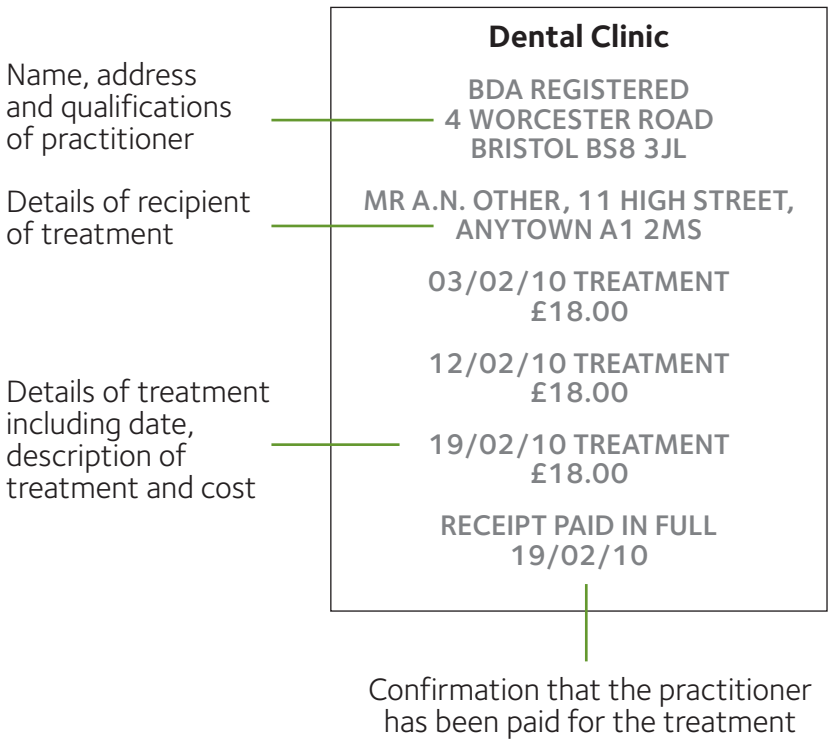
Making dental & optical claims

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 each policy. 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 14-15, or you can check by calling the Dental & Optical claims team on **0808 168 2912**.

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.
- 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 3 – Submit your claim form with receipt

- 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.

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 your provider insists on billing you, 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 35% share of the cost of these as you would with any other medical claim. We will pay for up to five sessions in total.

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 pages 15 and 16.
- 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.

9. Extra information

Further information

If you want any further information on any aspect of your cover, please call us on **0808 168 7775**.

Payment options

Premiums are paid by monthly Direct Debit.

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

If you decide to remove yourself from the scheme whilst still an employee of the company you should inform the person at the company who's running the scheme. Once we have a signed declaration from you, we will close your policy, end all cover, and return any money in the balance to the employer, though if you have paid money in, any of that money which remains will be returned to you. Cover will also end for any covered dependants.

What happens if I leave my current employment or reach the maximum age?

If you leave, either to take a new job or upon retirement or when you reach the maximum age under your scheme, you can transfer your cover details to an Individual Healthcare Deposit Account if one is still on sale. All money in your existing balance paid in by your employer, will be paid to your employer unless your employer's scheme provides for it to be returned to you under a scheme taken out prior to August 2009.

There are a few minor changes involved in transferring to an individual plan. The Individual Membership does not pay claims for eye tests, health screening or counselling helplines. However, you will be in charge of your deposit balance and can make cash withdrawals, subject to certain limitations. You will also be free to add other people to the policy with membership available to couples, and individuals or couples with children. If you continue as an Individual your premium can stay as it is or you can change it. You may have to pay a higher percentage of each claim once you transfer.

Adding others could change the level of premiums you pay and will alter the share of each claim you pay.

Upon leaving your employer, all money in the deposit balance that you haven't paid in will go back to the employer unless your employer's scheme provides otherwise. You must advise us of your choice within two months of leaving the Group scheme.

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

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 if one is still on sale.

Notice period

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

If the policy holder dies

If there is money remaining in the deposit balance that is due to be paid to the policy holder's estate or next of kin then we will need to receive a copy of the death certificate before this can be paid. If there is no money due to the policy holder's estate or next of kin the employer should contact us to cancel the policy.

All cover ceases, including that for covered dependants, from the date of death.

If we lose contact with an employee

If we lose contact with a policy holder or do not hear from the representatives of a policy holder who has died, we will move any money remaining in the deposit balance that is due to their estate or next of kin and not their employer to a holding account where it will earn a rate of interest determined by us. A valid claimant 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.

The Financial Services Compensation Scheme

The Financial Services Compensation Scheme (FSCS) protects consumers of virtually all financial services in the UK. Depending on the 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 claim, most insurance policies are covered for 100% of the first £2,000 of the claim and 90% of the rest. You can ask for more information from the FSCS on 020 7892 7300 or at www.fscs.org.uk.

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 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 independant 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 have:

- 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 **0808 168 7775** (8am-6pm weekdays).

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.

Words and phrases explained

Accident or Emergency Treatment
If an employee* needs to go to hospital immediately because they're suffering acute symptoms from an illness or accident, or if you* go to a hospital ward for unplanned urgent treatment. We will not pay for any subsequent private treatment unless you have been medically discharged from hospital.

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 an employee* to the state of health they were in before or which leads to an 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.
- An employee* needs to be rehabilitated or specially trained to cope with it.
- It needs long-term monitoring through consultations, check-ups, examinations or tests.

*or a covered dependant.

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 which, for medical reasons, means 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.

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

Deposit balance
The balance that 50% of your fixed monthly premium goes into and which funds part of each claim you make.

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

Eye test
A basic eyesight test as performed by an optician, optometrist or ophthalmologist and not including supplementary tests performed at extra expense.

Fixed monthly premiums
Monthly premium of which 50% goes into a personal deposit balance. 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.

Group Healthcare Deposit Account
The healthcare policy the employer has bought by signing our group application form and agreeing the terms of your 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.
- 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 an 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 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 an employee* has difficulty getting to in-patient or out-patient appointments, he/she may need to get treatment at home. An 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 an employee does not go in for day-patient or in-patient treatment.

Own share
The set percentage paid towards each claim from your deposit balance.

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.

*or a covered dependant.

Policy schedule
The document containing details of the Group Healthcare Deposit Account. We will give you your policy schedule when you join, and we will update it whenever your policy or other details change. The employer will also receive a policy schedule for the Group.

Pre-existing condition
Any disease, illness or injury 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 Group 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 plan this means England, Scotland, Wales, Northern Ireland, the Channel Islands and the Isle of Man.

*or a covered dependant.

NOTES

For extra information on this product or to request a copy in Braille, large print or audio please call us on:

0808 168 7775

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

Email enquiries@nationalfriendly.co.uk

Or alternatively contact your healthcare intermediary

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