



*EuroHealth  
Plan*

Policy Document

June 2006

EuroHealth is arranged by

**ibex**  
INSURANCE

Private Medical Insurance  
underwritten and administered by



**Exeter Friendly**  
— Society —

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## Introduction

Thank you for choosing Euro Health Plan, a private medical insurance plan arranged by Ibx Insurance and underwritten and administered by Exeter Friendly Society. This booklet sets out the private medical insurance cover available to you under your plan and as a member of Exeter Friendly Society. It also contains the full current rules, together with definitions of some of the terms used, and explains how to make a claim.

Please take a little time to read this booklet, together with your Policy Certificate. If anything is unclear to you, please call [Customer Support](tel:+441392353500) on +44 1392 35 35 00 or contact your local Ibx advisor, who will be happy to help you. The information in this Policy Document is valid only for cover from 1 June 2006. Amendments to its terms for renewals in subsequent years will be notified to policyholders with renewal documentation.

# Definitions

Where the following words or expressions appear in this document, they have the specific meaning set out below. To help you identify these words or expressions, they are shown in **bold italics** throughout this document, and may be referred to in the singular and/or plural. Where a person is referred to in the masculine, it includes persons of both genders.

## Accommodation

The charge made by a hospital for **in-patient treatment** or **day-patient treatment**. The charge includes the cost of the bed, meals, routine nursing and housekeeping.

## Acute Condition

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

## Benefit

The amount, in euro, that may be payable in respect of any eligible claim.

## Chronic Condition

A disease, illness or injury which has at least one of the following characteristics:

- it continues indefinitely and has no known cure
- it comes back or is likely to come back
- it is permanent
- you need to be rehabilitated or specially trained to cope with it
- it needs long-term monitoring, consultations, check-ups, examinations or tests.

## Customary And/Or Reasonable Fees

By **customary and/or reasonable fees** we mean the expected fees charged for **treatment**, facilities or equipment in the country or locality in which they are received, based on the fees charged to the majority of **our members** for those services in that location.

## Day-Patient Treatment

**Treatment** which, for medical reasons, means 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.

## Diagnostic Tests

Investigations, such as x-rays or blood tests, to find or to help to find the cause of your symptoms.

## Emergency Admission

An unplanned admission to any hospital (either state run or private) including (but not limited to) any admission arising from, and within a **day** of, a consultation with a primary carer or **specialist**.

## Excesses

An amount of eligible **benefit**, greater than, but inclusive of, the compulsory excess, that is waived by a **policyholder** for each **member** in a **year** in return for a reduced **premium**. See how the excesses work on page XX and rule 6.5 on page XX

## Family Member

**Your** partner and **your** unmarried children (and those of **your** partner) under the age of 21 at the commencement of cover or any subsequent **renewal date** and who are included on your **policy**. By partner, **we** mean

**your** husband or wife or the person with whom **you** live permanently in a similar relationship. By children, **we** mean any child for whom **you** or **your** partner holds the position of a legal guardian.

## Home Nursing

Skilled nursing by a **qualified nurse** at home immediately following **in-patient treatment** or **day-patient treatment**. The nursing must be recommended and supervised by the **specialist** who treated the **member**, and required for medical as opposed to domestic reasons.

## In-Patient Treatment

**Treatment** which, for medical reasons, means you have to stay in hospital overnight or for longer.

## Member

**You** and any **family member** included in your **policy** and named on your **Policy Certificate**.

## Oncology

The specialist **treatment** of cancer, which includes radiotherapy and chemotherapy. The **specialist** is called an oncologist.

## Orthoses

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

## Out-Patient Treatment

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

## Plan

Any one of the private medical insurance schemes provided by the **Society**.

## Policy

The written agreement with the **Society** under which you are entitled to claim **benefits** contained in the documents listed in rule 1.1.

## Policy Certificate

The document issued by the **Society** as evidence of your **policy**.

## Policyholder

The person who has taken out the **policy**, and is identified as such on the **Policy Certificate**.

## Pre-admission Tests

A clinical assessment required to determine a patient's fitness and suitability for anaesthesia and surgery, which may also detect unsuspected conditions that might affect the patient's surgery. These tests are not diagnostic.

## Pre-existing Condition

Any disease, illness or injury, for which:

- you have received medication, advice or **treatment**; or
  - you have experienced symptoms;
- whether the condition has been diagnosed or not in the five years before the start of your cover.

## Premium

The amount payable to the **Society** for **members** to belong to a **plan**.

## Primary Care

General Practitioner (GP) consultations, or the specialist acting in the capacity of, or carrying out GP Services.

### Professional Sport

A sport where a fee or benefit in kind is received, paid or made available, either directly or indirectly, for playing, training or any other reason.

### Prosthesis

An internal, permanent replacement of a missing body part but specifically excluding implantable ventricular defibrillators (unless specifically authorised in advance), artificial limbs, artificial heart pumps or cochlea implants.

### Qualified Nurse

A nurse who is on the Professional Register of Nursing in the country in which the **treatment** is received.

### Reasonable And/Or Customary Fees

See **Customary And/Or Reasonable Fees**.

### Renewal Date

The anniversary of when your **policy** began, or any other date determined by the **Society** in writing.

### Society

Exeter Friendly Society Limited.

### Specialist

A healthcare professional to whom a **member** is referred by his medical practitioner or other primary care physician for secondary care. This person must have the appropriate qualifications, must belong to a recognised professional regulatory body and must carry

adequate indemnity insurance.

### Treatment

Surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

### United Kingdom (UK)

Great Britain, Northern Ireland, Channel Islands and the Isle of Man.

### We/Our/Us

Exeter Friendly Society Limited

### Year

A period of twelve calendar months from the date the **policy** began or from any subsequent **renewal date**.

### You/Your

When printed in **bold italics**, **you/your** refers to the **policyholder**. When printed in plain type, you/your refers to any persons included on the **policy**.

# Language Used & Law Applicable

When providing services under your **policy**, the language **we** will use will be English. In accepting **our** service you agree that the law of England and Wales will determine the establishment and performance of your **policy**, subject to **our** compliance with any local regulation or legal requirements. In respect of performance and formation of this arrangement, you agree that the courts of England and Wales have exclusive jurisdiction.

## Demands & Needs Statement

EuroHealth meets the demands and needs of a person who is resident in Portugal or Spain, and who is looking to insure against the costs of private **treatment**, received on an in-patient, day-patient or out-patient basis, for acute medical conditions that arise after joining the **Society**.

In selecting EuroHealth you acknowledge that cover is not available for the **treatment** of medical conditions that the **Society** deems as chronic in nature, nor for the conditions listed as exclusions in section 8 of the rules contained within this Policy Document.

You also recognise that cover is limited according to the level selected as detailed in the Table of Benefits and rules described in this

Policy Document and that, therefore, in certain circumstances, the **benefits** available may not fully cover the costs of **treatment**. Even when benefits are available you acknowledge that there is a compulsory excess on the EuroHealth Plan which means that the benefits which would otherwise be payable in respect of each person covered by your policy, will be subject to a deduction of #100 in any year.

You have accepted that all **premiums** and **benefits** have to be paid in euro and, therefore, you may be affected by movements in exchange rates if **treatment** is received in a non-eurozone country.

If taking one of the additional voluntary **excess** options in order to reduce the **premium** payable, you accept that the **benefits** which would otherwise be payable in respect of each person covered by your **policy** in any **year**, will be subject to a deduction equal to the amount of **excess** taken.

### Other Products

If your demands and needs have changed since you took out your current cover, or are no longer met by the terms of your **policy**, please call **Ibex Insurance** on +350 77822 or, consult with the intermediary or advisor who arranged your **policy** for further advice about the other options available to you.

# Important Notes For New Policyholders

Please bear in mind that utmost good faith is a very important principle in insurance. **Your** signed and dated application form is an integral part of your **policy** and the cover **we** provide. If it contains materially incorrect or incomplete facts **we** have the right to refuse payment of a claim or cancel your cover.

**You** should therefore have taken the greatest care to ensure that **you** completed the application form fully and accurately, and that you did not withhold any material facts that may affect the terms of acceptance.

**Please Note** - if any changes occur, or have occurred, in the facts given by you between the date on which you completed your application form and the date your **policy** becomes effective, you must inform the **Society** immediately.

Please check carefully all the documents sent to **you** by the **Society** to ensure that the insurance cover meets your requirements. If you are not entirely satisfied with the terms of **your policy** with the **Society** and the extent of the **benefits** provided, **you** may cancel your cover.

**We** will cancel **your policy** if **you** advise **us** that **you** wish to cancel the cover not later than 14 days after **we** confirm **your** cover to **you** or 14 days after the commencement date of the **policy** if later.

**We** will refund **premium** payments made under the **policy** less a sum representing a fair **premium** for the period for which the **policy** was on risk, calculated on a pro rata basis.

## Paying Your Premium

You are responsible for ensuring that premiums are paid on time.

Premiums for this plan must be paid using one of the following payment methods:

-annually by Direct Debit (5% discount)

-monthly by Direct Debit

-annually by credit card (Visa or Mastercard only)

-annually by cheque made payable to Exeter Friendly Society

### **Please Note**

We do not accept payment by American Express.

Only payment by annual Direct Debit (i.e. by one Instalment) attracts a premium discount of 5%.

Direct Debit payments are currently accepted from Portuguese or Spanish euro bank accounts only.

### Factors influencing **premium** rates

Increases to **premium** rates are applied on each annual **renewal date** of your **policy**. In general the **Society** will aim to ensure that

**premiums** for each **plan** and **plan** level are at least sufficient to cover the expected claims and expenses over the long term. From time to time the **Society** may decide that **premiums** need to be lower or higher than this in order to use up or accumulate some of its reserves and to ensure fairness to its **members**.

The main factors which influence the **premium** increases are:

- the recent incidence of claims within your **plan** and level of cover
- the size (i.e. monetary amount) of those claims
- expected future changes in claim patterns
- changes to the **benefits** covered by your **plan**
- your age on renewal
- expenses of running the business including Insurance Premium Tax and other government taxes and levies
- investment returns on the **Society's** reserves
- the current level of **premiums** relative to the above factors.
- the impact of inflation
- changes in the policy profile within a **plan** or level of cover
- the level of reserves held by the **Society**
- statutory solvency and other requirements.

Typically the combination of these factors means that premiums are likely to rise at a rate greater than retail price inflation.

### Friendly Society status

Because **we** are a friendly society all surpluses are retained for the benefit of **members** rather

than being paid out to shareholders. This may lead to:

- improved security of **benefits** through the **Society's** increased financial strength
- more generous cover on the **Society's plans**
- **premiums** being held at a lower level than would otherwise have been the case.

However, because **we** have no shareholders the **Society's** only source of capital is its **members**, so **we** have a duty to ensure that the **Society** remains financially strong at all times in order to protect **members' benefits**. Therefore the **Society's** continued financial well-being will always be an overriding objective in the setting of **premiums**.

## Paying Your Premium

You are responsible for ensuring that **premiums** are paid on time.

**Premiums** for this **plan** must be paid in euro using one of the following payment methods. Only payment by annual Direct Debit (i.e. by one instalment) attracts a **premium** discount of 5% Direct Debit payments are currently accepted from Portuguese or Spanish euro bank accounts only:

- annually by Direct Debit (5% discount)
- monthly by Direct Debit
- annually by credit card (Visa or Mastercard only)
- annually by cheque made payable to Exeter Friendly Society.

Please note: **we** do not accept payment by American Express.

## Renewing Your Policy

Your **policy** with the **Society** will run initially for a **year** from the date on which you first join. This means that you do not have to commit yourself to a long-term contract, and you can reconsider your position each **year**.

Equally, **we** are not committed to remaining your medical insurer for more than one **year** at a time. However, **we** appreciate that you may wish to have some assurance that you will be able to renew your cover each **year**. You can generally expect to be able to renew **year** after **year** at the price **we** quote for the coming **year** for the **plan** (and the level of **benefits**) to which you currently belong, as long as the **plan** is still being offered and you satisfy the eligibility conditions contained within the Policy Rules. By this, **we** mean that **we** will never arbitrarily or unreasonably refuse to renew your **policy**. In rare cases, where **we** decide that the **policy** should not be renewed, **we** will always give you due notice of **our** intention to refuse renewal.

Some reassurance about renewal may also be of value for the following reason: although the **Society** does not normally cover **pre-existing conditions**, if you continue your **policy**, **we** will regard the date on which you joined the **Society** as the date for considering whether or not your condition is looked upon as pre-existing.

Where renewal is offered, **we** will write to **you**

at least 21 days before your **renewal date** confirming the terms of your cover for the coming **year**, including the revised **premium** to be paid. If you have a Direct Debit arrangement in place to pay your **premium**, **we** will continue to apply that arrangement to **your policy**, at the revised rate, unless **we** hear from **you** to the contrary.

### Dependent children

If you include a child on **your policy**, please note that they may continue to be covered until **your** first **renewal date** on or after their 21st birthday. At this date, they may continue their existing cover by taking out a **policy** in their own right and paying the premium applicable to a policyholder of their age.

## Cancelling Your Policy

If **you** wish to cancel **your policy**, please contact **us**, and **we** will effect the cancellation as soon as is allowed under the rules of your **plan**. If you notify **us** within 14 days of the commencement of your **year**, **we** will refund any **premiums** already paid for that **year**, less an amount of **premium** to cover the period your **policy** was on risk. This is **your** statutory right to cancel. If **you** do not exercise this right, **you** can only terminate by not renewing for the next **year**. Cancellations at any other time are allowed at the sole discretion of the **Society**, and any decision will take into account any **premiums** or claims already paid in the current **year**. On no account will the **Society** refund a **premium** that relates to a

period prior to the date **we** receive your request to cancel except as allowed upon joining and renewal, or in the event of the death of a **member** (please refer to rule 4.5).

## Excesses

There is a minimum excess of €100 on the EuroHealth Plan. You may have chosen to voluntarily increase the excess in order to reduce your premiums. An excess means that you waive entitlement to any **benefits** to which you would otherwise have been entitled, up to the value of any **excess**, for each **member** included on your **policy**. The level of excess applying to your policy is shown on your Policy Certificate

**We** apply any **excess** to each person on the **policy** each **year** if a claim is made. The **excess** starts again at your renewal date, so if you have any **treatment** which spans two **years**, the **excess** will be applied twice, once for each **year**.

Any **benefit** entitlement waived because of an **excess** still counts towards your **benefit** limits as if we had paid the **benefit** in full.

When you have **treatment** for an eligible condition that you know will not be covered because of any **excess**, you will still need to send the invoices to **us** so that **we** can take these into account when checking any future claims.

When **we** receive invoices for any **treatment** you have had, **we** will:

- check the invoices to make sure that all the charges made are covered under your **plan**
- apply any **benefit** limits on your **plan** to the invoices
- deduct any **excess** from any payments due
- write to **you** telling **you** how much **we** have paid, and let **you** know whether or not **you** need to pay anything to the **specialist** or hospital.

In addition to the compulsory excess of €100 you also have the opportunity to take out an additional voluntary excess in order to reduce your premiums. The amounts of additional voluntary excesses and discounts available to you are as follows:

- 10% for a €500 **excess**
- 20% for a €1,000 **excess**

Occasionally **we** may decide to review either the levels of **excess** offered or the discounts that relate to them. If **we** do this, **we** will let **you** know before your **renewal date**.

Here are some examples of how the **excess** works:

### Example 1

Margaret has Level 1 cover with an **excess** of €100. Her **policy** runs from 1 March each **year**. In July, she sees her GP and her claim is approved by **us**. The **specialist** charges her €35. This is her first eligible charge in this **year**. As she has the compulsory **excess** of €100, she will need to pay this invoice herself, and send the invoice to **us** so that **we** can take

this into account when paying any further claims this **year**.

She has two further consultations in August and September, and the **GP** charges €35 each time. **We** will pay €5 towards the cost of these charges. **We** will then write to Margaret to advise her that she needs to pay the remaining €65, because of the outstanding amount on her compulsory **excess**.

In October, Margaret again sees her GP for a different medical condition, and sends **us** an invoice for a further €35. As the compulsory **excess** is applied to each person on the **policy** each **year**, and not to each medical condition, **we** will pay this invoice in full.

## Example 2

Steven has Level One cover with an **excess** of €300. His **policy** runs from 1 September each **year**. On 30 August, he is admitted to hospital for surgery. He has already paid €160 of his **excess** for the **year** for previous eligible charges. He is discharged on 2 September so his **treatment** spans two **years**.

The hospital sends **us** an invoice for €2,400. **We** then deduct €340 from the amount payable to cover the remaining **excess** for the first **year**. However, **we** will then deduct a further €500 in order to cover the **excess** for the second **year**. **We** will therefore pay €1,860 to the hospital and Steven will need to pay the outstanding amount of €580.

	Year 1	Year 2
	€	€
<b>Excess</b>	500.00	500.00
<b>Already paid</b>	160.00	-
<b>Excess still to pay</b>	<b><u>540.00</u></b>	<b><u>500.00</u></b>

**Total of invoice for treatment 30 August - 2 September** €2,400

**Remaining excess payable by Steven (Year 1)** €340

**Excess payable by Steven (Year 2)** €500

**Total excess payable by Steven (€840)**

**Remaining amount payable by us** **€1,560**

## Example 3

Mary has Level 2 cover with a voluntary **excess** of €500. Her **renewal date** is 1 June. In January, she injures her ankle and is referred to a physiotherapist. She has ten sessions of physiotherapy at a cost of €35 per session, and sends the invoices to **us**.

Initially, **we** apply the **benefit** limits of her **plan**, which allows up to €250 per **year** for physiotherapy. This means that only €250 of the €350 **treatment** costs are eligible for **benefit**. However, as Mary also has a voluntary **excess** of €500 on her **policy**, **we** will then deduct this from the €250, so **we** will not be liable for any of the costs. Mary will therefore need to pay all €350 of the costs herself. Her remaining **excess** is €250 and this will be applied if she makes any further claims for **benefit** before her next **renewal date**.

The following shows what would have been payable had only the compulsory excess *applied*, together with the amount payable with the voluntary excess.

	No Excess	€250 excess
	€	€
<b>Total of Invoices</b>	350.00	350.00
<b>Benefit available</b>	250.00	250.00
<b>Excess deductible</b>	100.00	500.00
<b>Amount payable by us</b>	<u>150.00</u>	<u>0.00</u>
<b>Amount payable by Mary</b>	<u>200.00</u>	<u>350.00</u>

Mary has also used all her complementary treatment *benefit* until her next *renewal date* and any further invoices received are still subject to the remaining *excess* amount of €250 being deducted from the amounts claimable for the *year*.

### Example 4

Catherine has taken out Level 1 cover with a voluntary *excess* of €1,000, and has included her daughter on her *policy*. The *policy* runs from 17 September. In October, her daughter is admitted to hospital and her *treatment* costs €1,500. **We** will deduct €1,000 from this to cover the voluntary *excess*, and will pay the remaining €500.

In March, Catherine is also admitted to hospital and the *treatment* costs €2,600. Because the voluntary *excess* is applied to each person on the *policy* each *year* if an eligible claim is submitted, **we** will deduct Catherine's voluntary *excess* of €1,000 and pay the remaining €1,600.

### Example 5

David has Level 2 cover with a voluntary *excess* of €500. He sends **us** invoices for osteopathy totalling €400. The maximum *benefit* claimable by David for osteopathy is €250, therefore this is the maximum amount he can offset against his voluntary *excess* for the current *year* and the full €400 is payable by David. He has also used all his complementary treatment *benefit* until his next *renewal date*.

The following shows what would have been payable had only the compulsory excess applied, together with the amount payable with the voluntary excess.

	Compulsory Excess	€500 excess
	€	€
<b>Total of Invoices</b>	500.00	500.00
<b>Benefit available</b>	250.00	250.00
<b>Excess deductible</b>	100.00	500.00
<b>Amount payable by us</b>	<u>150.00</u>	<u>0.00</u>

Amount payable by David

250.00

400.00

David has now used all his complementary treatment **benefit** until his next **renewal date** and any further invoices received are still subject to the remaining voluntary **excess** amount of €250 being deducted from the amounts claimable for the **year**.

## Increasing or reducing your level of excess

**You** can only increase or reduce your level of voluntary **excess** with effect from your **renewal date**. If **you** increase your level of voluntary **excess**, **we** will apply your new higher voluntary **excess** amount to any claims you make after your **renewal date**.

If **you** reduce your level of voluntary **excess**, any claims for new conditions made after this change will have the new lower voluntary **excess** amount applied. However, any ongoing medical conditions, which began before your **renewal date** will have the old higher voluntary **excess** amount applied to them.

Here are some examples of how this works:

### Example 1

Sarah has an **excess** of €500. Her **renewal date** is 1 June, and after a **year** of having the **policy** she decides to increase this **excess** to €1,000. In September, she makes a claim. **We** will apply her new **excess** of €1,000.

### Example 2

Tom has an **excess** of €1,000. His **renewal date** is 15 August and he decides to reduce his level of **excess** to €500. In December he begins to get pain in his hip and is referred to a **specialist**. He has not had any previous problems with his hip. **We** will, therefore, apply his new **excess** of €500, as this is a new condition.

### Example 3

Sheila has an **excess** of €500. Her **renewal date** is 1 February, and she decides to remove her voluntary **excess** of €500. In January, she went to see her GP about a medical condition and he referred her to a **specialist**.

She sees the **specialist** on 3 February and is later admitted to hospital for **treatment**. **We** will, therefore, apply the original **excess** of €500, because the condition started before she changed to the new **excess** level.

# A Guide To Making A Claim

When a medical practitioner or primary care physician wants **you** or any of the other persons on **your policy** (hereinafter referred to as the “patient”), to see a **specialist** or have some tests, and **you** intend to apply for **benefit** from the **Society**, there are a few things **you** must do before the patient visits the **specialist** or has any tests.

## New medical conditions

### Contact us.

Please telephone [Customer Support](#) on +44 1392 35 35 00 as soon as possible. **You** and/or the patient (if not **you**) will be asked some questions about the medical condition requiring referral and the **specialist** to whom the patient has been referred. From the responses provided, **we** will usually be able to confirm immediately whether or not **benefit** may be available. If so, **we** will issue a form for the patient to take along to the **specialist**, which requests further information about the medical condition and, where applicable, the proposed **treatment**. By signing this form the patient will be authorising that the **specialist** may release to the **Society** a copy of the medical practitioner’s or primary care physician’s referral letter to the **specialist**. If the patient does not consent **we** reserve the right to refuse the claim.

When the patient visits the **specialist** **we** strongly recommend that he takes along this Policy Document, as the **specialist** may need to refer to it in order to establish if the proposed **treatment** is covered by the **benefits** available. In certain circumstances, **we** may need to contact, or obtain reports from, others involved in the patient’s **treatment** and, if so, **we** will need separate consent from the patient for this.

## Arranging Your Treatment

Once the fully completed form and copy of the original referral letter have been returned to **us**, **we** will assess whether the proposed **treatment** is eligible for **benefit** and, if approved, the patient may proceed with the **treatment**. In order to improve the service to our members the Society has become a member of CareBridges International. Should it be necessary for you to have a scan or be admitted to hospital, please ensure that you contact Customer Support on +44 1392 35 35 00 before your visit to the hospital so that we can arrange your admission through our Portuguese or Spanish partners. If, as the **treatment** progresses, you have any queries about the claim or the extent of the **benefits** available to cover the costs incurred, please telephone [Customer Support](#) on +44 1392 35 35 00 for advice.

Please Note: Hospitals outside the **UK** may request pre-payment from you prior to your admission unless this has been arranged through our CareBridges partner.

## Ongoing medical conditions

If you need a further consultation/ **treatment** for a condition that has already been approved and registered with the **Society**, please contact **us** and let **us** know what **treatment** is proposed, the **specialist's** name and, if appropriate, the admitting hospital. Please ensure that you contact Customer Support on +44 1392 35 35 00 before your visit to the hospital so that we can arrange your admission through our Portuguese or Spanish partners. **We** will then check that your proposed **treatment** is in accordance with your chosen **plan** and level of cover and that you have the **benefits** available to enable **us** to assess and settle any invoices **we** receive for your **treatment**.

## Payment of Invoices

**We** are able to settle invoices directly with most hospitals and **specialists**. They can forward invoices directly to **us**, and **we** will deal with them for you, saving you time and expense.

If you wish **us** to settle invoices directly for you, please tell the hospital and/or **specialist** your **policy** number and claim number, both of which will be shown on **our** letter of approval. This will help **us** to avoid delays in settling the invoices.

When **we** have settled an invoice for you, **we** will write to **you** and confirm how much **we** have paid. **We** will also advise **you** if you need to pay for any of the **treatment** because it is not eligible under your **plan**, or because of the **excess** on your **policy**, or because you have reached a **benefit** maximum.

If you do have to settle an invoice yourself and wish **us** to reimburse **you**, **we** will require the original, itemised invoice, together with **your** request for reimbursement quoting your **policy** number and claim number. All payments will be made by cheque in euro.

**We** strongly recommend you to check the invoices you receive and inform the provider or **us** of any discrepancies.

Please note: **we** are unable to accept photocopied or e-mailed invoices.

## Chronic Conditions

### Introduction

The following information is designed to explain what a **chronic condition** is, and how **we** would deal with any claims you make for a condition which **we** consider to be chronic.

#### Q. What is a **chronic condition**?

A. A **chronic condition** is a disease, illness or injury that has at least one of the following characteristics:

- it continues indefinitely and has no known cure
- it comes back or is likely to come back
- it is permanent
- you need to be rehabilitated or specially trained to cope with it
- it needs long-term monitoring, consultations, check-ups, examinations or tests.

**We** will not cover **chronic conditions** following the initial diagnosis and therapy.

# EuroHealth Table Of Benefits

	Level 2	Level 1
<b>Overall Maximum Benefit</b>	<b>Unlimited</b>	<b>Subject to individual Benefit limits</b>
<b>In-Patient &amp; Day-Patient Benefits</b>		
Hospital Charges	Paid in Full*	€30,000 per year
Specialist Services	Paid in Full*	
Pre-Admission Tests	Paid in Full*	
<b>Out-Patient Benefits</b>	<b>Level 2</b>	<b>Level 1</b>
Out-Patient Services	€2,500 per year	€1,500 per year
Complementary Treatment (Such as physiotherapy, osteopathy & chiropractic)	€250 per year	No Benefit available
<b>Additional Benefits</b>	<b>Level 2</b>	<b>Level 1</b>
Oncology	€75,000 per year	€30,000 per year
Home Nursing	€250 per year	No Benefit available
Private Ambulance	€250 per year	No Benefit available
Primary Care	€150 per year	€75 per year
UK Cover	€25,000 per year	No Benefit available

**\*Important Note:** Even when expressed as paid in full, all costs must be eligible and necessary for the **Society** to be **reasonable and customary** for the **treatment** received. These individual benefits

## Notes

The total *benefit* available per year for each person included on the *policy*

## Notes

Includes **accommodation**, nursing, theatre fees & consumables, surgical drugs & dressings, **diagnostic tests**, scans, physiotherapy, pathology & eligible **prostheses** whilst you are an in-patient or day-patient.

Surgeon's, anaesthetist's and physician's fees for **in-patient treatment** & **day-patient treatment**.

These will be included as part of your day-patient/in-patient hospital charges providing they are carried out within the two weeks prior to your admission.

## Notes

For **specialist** consultations, minor surgery, **diagnostic tests**, x-rays and scans.

**Treatment** must be carried out by a doctor or practitioner who holds a certificate of specialist training recognised by the **Society**.

## Notes

Includes radiotherapy and chemotherapy under the management of an oncologist. To include monitoring required during each course of active **treatment**. (Cancer surgery is paid out of the In-Patient & Day-Patient Benefits.)

Payable for medical as opposed to domestic reasons and must be undertaken under the supervision of the attending **specialist**.

Payable towards the cost of a private road ambulance to, from or between hospitals. The use of the ambulance must be medically essential and required in connection with eligible **in-patient treatment** or **day-patient treatment**.

For home and surgery visits and **diagnostic tests**, but excluding the cost of drugs and dressings.

Payable for treatment in the UK. Treatment costs incurred will count towards the individual benefit limits, where applicable.

arily incurred and **benefit** will be paid in accordance with those fees deemed by the **fit** limits shown are still subject to the Overall Maximum Benefit on your **plan**.

Please note, however, that **we** do not consider cancer to be a **chronic condition**. The following answers and examples are designed specifically to address chronic conditions and how they are dealt with, but are all subject to the excesses, where applicable.

#### Q. What does this mean in practice?

A. When you are referred to a **specialist** by your medical practitioner or primary care physician, **we** will request some information about the condition for which you wish to claim **benefits**. **We** will check this (and any supporting information) to make sure that **we** can cover your claim.

If **we** consider the condition for which you need **treatment** to be chronic, **we** will only cover the initial investigations leading to a confirmed diagnosis, and the initial **treatment** needed to stabilise the condition (providing the **treatment** is covered under your **plan**).

**We** will not pay for any **treatment** once the diagnosis has been made and the condition has been stabilised.

#### Q. What if your condition gets worse?

A. In some cases, **we** will pay for further **treatment** if your condition gets worse. **We** may pay for **treatment** relating to an acute episode of a **chronic condition**.

For example, **we** consider asthma to be a **chronic condition** and do not pay for any ongoing **treatment** or monitoring. However, an asthma attack would be classed as an acute episode.

**We** may consider paying for **treatment** to

stabilise the condition providing that the particular **treatment** is covered under the **plan** and there is **benefit** available. In order to consider this **we** usually request a medical report or ask for additional information.

## Examples of Chronic Conditions

### Example 1

Alan has been with the Exeter Friendly Society for many **years**. He develops chest pain and is referred by his medical practitioner to a **specialist**. He has a number of investigations and is diagnosed as suffering from angina. Alan is placed on medication to control his symptoms.

**We** do not consider angina to be a **chronic condition**. This means that as long as Alan's claim has been approved by **us**, and the investigations are covered under the **benefit** limits of the **plan**, **we** will pay **benefits** for these investigations. **We** will not, however, pay for the medication.

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

**We** will pay for the operation and any follow-ups needed, as long as **benefits** are available for these under the terms of Alan's particular level of cover.

### Example 2

Carole develops a lump in her left breast which is diagnosed as breast cancer. Her **specialist** recommends that she has a

mastectomy (breast removal) followed by a course of chemotherapy and radiotherapy.

**We** do not consider cancer to be a **chronic condition**. Providing this is a new condition, and the claim has been approved by **us**, **we** will pay for the initial consultation, operation, chemotherapy and radiotherapy, up to the **benefit** limits of her chosen **plan**.

Once Carole's course of **treatment** has been completed, her **specialist** recommends that she has regular check-ups to ensure that she remains free from a recurrence of the disease.

Providing Carole has **benefits** available under her particular level of cover, **we** will pay for these check-ups.

### Example 3

Bob has been with the Exeter Friendly Society for three **years** when he develops hip pain. His medical practitioner refers him to an osteopath who treats him every other day for two weeks and then recommends that he return once a month for additional **treatment** to prevent a recurrence of his original symptoms.

Once **we** have approved the claim, **we** will pay for the cost of the osteopathy **treatment** providing Bob has **benefit** for osteopathy under his chosen **plan** and he has not reached his **benefit** limit.

### Example 4

Deidre has been with the Exeter Friendly Society for two **years** when she develops symptoms that indicate she may have diabetes. Her medical practitioner refers her to

an endocrinology **specialist** who organises a series of investigations to confirm the diagnosis, and then she starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments to the medication regime, the **specialist** confirms that the condition is now well controlled and explains that he would like to see her every four months to review the condition.

**We** consider diabetes to be a **chronic condition**. Providing the claim is approved by **us**, **we** will pay for the initial consultation and investigations, up to the **benefit** limits of the **plan**. **We** will pay for follow-up consultations until the condition has been stabilised providing Deidre has not reached her **benefit** limit. However, **we** will not pay for the medication prescribed.

One **year** later, Deidre's diabetes becomes unstable and her medical practitioner arranges for her to go into hospital for **treatment**.

**We** may consider this to be an acute episode and, therefore, pay **benefits** providing the **treatment** is covered under Deidre's chosen level. **We** would usually request a medical report or ask for further information in order to consider this.

### Example 5

Eve has been with the Exeter Friendly Society for five **years** when she develops breathing difficulties. Her medical practitioner refers her to a **specialist** who arranges for a number of tests. These reveal that Eve has asthma. Her

**specialist** puts her on medication and recommends a follow-up consultation in three months to see if her condition has improved. At that consultation Eve states her breathing has been much better. So the **specialist** suggests she has check-ups every four months.

Providing the claim is approved by **us, we** will pay for the initial consultation and tests, up to the **benefit** limits of the **plan**. Once the condition has been stabilised, **we** will not pay for the check-ups.

Eighteen months later, Eve has a bad asthma attack.

**We** may consider this to be an acute episode and, therefore, consider paying for further **treatment** for this providing **benefits** are available under her chosen **plan** and the **treatment** recommended is covered. **We** would usually request a medical report or ask for further information in order to consider this.

## GP Helpline: +44 118 936 5655

Your **policy** with the **Society** gives you access to a UK GP Helpline, which is open 24 hours a day, 7 days a week. This helpline is provided by an independent company selected by Exeter Friendly Society. You can take advantage of this service at any time, so you do not need to wait until you need to make a claim.

You can use this helpline if you need more detailed information about your symptoms, or for more information about a diagnosis or treatment.

Dedicated operators will take any information needed and then arrange a convenient time for a private UK GP to return your call. You will only be charged for the initial call to the helpline operator.

## Our Standards

**We** aim to provide you with access to **plans** that are affordable, and provide for your future wellbeing. **We** always act with the highest ethical standards of conduct and professional integrity whilst striving to meet, and exceed, members' expectations.

**We** try to achieve the following service standards:

- to respond to **your** application for a **policy**, or to amend cover, within five working days
- to process properly presented, eligible claims within ten working days
- to respond to your correspondence and any other **policy** queries within five working days

## .If You Are Not Satisfied

The **Society** provides medical insurance for almost 50,000 people. **We** receive a large

number of enquiries, together with many claims and requests for information. **We do our best** to ensure that these are dealt with quickly and efficiently. However, **we** welcome any new ideas or suggestions that you believe would improve the products provided, the level of service or the standards of management.

## Making a complaint

Although **we** are committed to providing you with the highest level of service, **we** do not always get it right. If you are not satisfied with any aspect of the service **we** provide, or the efficiency of **our** response, please refer the matter to [Customer Support](#), who should be able to resolve it to your satisfaction.

However, if they are unable to do so, they will refer the matter to the appropriate manager and/or director. If the problem cannot be resolved immediately, **we** will advise you within two working days, telling you how long **our** investigations are likely to take.

If you are still not satisfied with the outcome, **we** will refer your complaint to **our** Quality Controller, who will investigate your complaint separately. You will receive a further response within two working days of receipt of the complaint by the Quality Controller. **We** will provide a full response to your complaint within the following two weeks, provided **we** have received all the information **we** require from any third parties involved.

## If you are still not satisfied

If you feel that your complaint has not been resolved by the end of eight weeks from **our** receipt of your complaint (or if **we** have failed to issue an explanation for the delay in dealing with your complaint by the end of four weeks), you can refer the matter to the Financial Ombudsman Service. Full details will be provided by the Quality Controller with the **Society's** final response.

The existence of the Financial Ombudsman Service does not prejudice your right to take legal action in the event of a dispute.

**We** treat complaints very seriously, and all complaints are recorded and monitored regularly by the Board of Directors. **We** believe that this enables the **Society** to improve and enhance services on a continuous basis.

## Financial Services Compensation Scheme (FSCS)

Exeter Friendly Society is covered by the FSCS, which was established under the Financial Services and Markets Act 2000.

Under the scheme, you may be entitled to compensation, in the event that a Financial Services Authority authorised firm, such as Exeter Friendly Society, becomes insolvent and is unable

to pay claims.

For private medical insurance the scheme pays the first £2000 of a valid claim in full and 90% of the remaining amount of the loss.

This scheme is only available to **members** who are resident within the EEA.

Further details are available from the Financial Services Compensation Scheme at [www.fscs.org.uk](http://www.fscs.org.uk) or telephone 020 7892 7300.

## Data Protection

**We** hold information about you in order to provide and administer your **policy** with **us**. Your personal information will be treated in confidence and will only be used by the **Society** for the following purposes:

- The assessment and management of your medical insurance, including contacting you on an annual basis regarding the renewal of your **policy** and processing claims.
- Transmission to those involved in your **treatment** or care.
- Retaining cancelled **policies** and associated details to assist **us** in determining future applications for insurance that you may wish to make.
- Transmission to carefully selected third parties (including the intermediary who arranged your **policy**, if any) as part of **our** administrative operations.
- Transmission to carefully selected third parties for the purpose of research,

advertising, marketing or selling (for example to develop and advise you of new products).

- As may be required or permitted by law or as appropriate to detect and prevent fraud and improper claims.

**Our** purposes for holding, and **our** uses of, personal information, are listed in the Register of Data Controllers. You may inspect this, or obtain a copy of the relevant entry from the Office of the Information Commissioner (and at their website:

[www.informationcommissioner.gov.uk](http://www.informationcommissioner.gov.uk)).

In order to provide you with insurance **we** will need to process sensitive information (such as medical information) about **you** and the others named on your **policy**. Please get consent from the people named on your **policy** before sharing their sensitive information with **us**.

At the request of many of **our** members and to make managing your private medical insurance more convenient, **we** may deal with your spouse or partner who telephones **us** on your behalf, if they are included on your **policy**. If you would like someone else to deal with your **policy** on a regular basis, or if at any time you would prefer **us** to deal only with you, please let **us** know.

**We** have a responsible mailing policy, and may contact you from time to time to inform you of products or services that **we** provide, or **we** may pass your details to other carefully selected organisations whose services **we** think may be of interest to you. If you would like to continue to receive this information, you need take no

further action. However, if you would prefer not to be part of **our** mailing programme, please write to the Administration Manager at the address shown on the reverse of this document.

Under the terms of the Data Protection Act 1998, you may request a copy of the details **we** hold about you on **our** computer systems. **We** reserve the right to charge a fee for this service, up to the maximum allowed by the Act. If you require a copy of such information, you should write to the Compliance Director, at the address shown on the reverse of this document.

## Policy Rules

### 1. Policy Terms

1.1 The terms of the **policy** are contained in the following documents, all of which must be read together:

- the Policy Rules in force when the **policy** begins, or as amended on renewal
- the table of **benefits** in force when the **policy** begins, or as amended on renewal
- the **Policy Certificate**
- any application form which **you** have been required to complete.

In the event of a conflict between any of the documents listed above, the Policy Rules in this Policy Document shall prevail.

1.2 None of the **Society's** employees or intermediaries are entitled to make any alteration or amendment to the terms of the

**policy** unless it is made in writing and signed by the **Society**.

### 2. Joining & Renewal

2.1 The **policyholder** is required to complete the correct form to join a **plan**, change their level within a **plan**, change to another **plan** or amend the level of **excess**. The **policyholder** is responsible for ensuring that to the best of their knowledge and belief, the information given to the **Society** about every person included on his application is true, accurate and complete.

2.2 Upon the death of a **policyholder**, a spouse or partner who is registered as a **family member** may without formality become the **policyholder** in his own right.

2.3 Any request for changes to a **policy**, must be made on the appropriate form where applicable or in writing by the **policyholder**.

2.4 Any **member** rejoining the **Society** following cancellation will be required to complete a new application form and the **Society** may impose different terms to those previously offered. The **Society** may, at its discretion, allow reinstatement of the **policy** upon receipt of a declaration of health, payment of the outstanding **premiums**, and an administration fee of €150.

2.5 Children born to the **policyholder** after the start of the **policy** may only be added, with proof of their health, at the age of three months or at a later date.

2.6 The **Society** is entitled to refuse to accept any person as a **member** without giving a

reason. The **Society** may require a **policyholder** to submit a medical report in respect of any person included in his application, and/or to prove their age.

2.7 The **policy** is for a period of one **year**. If the **plan** is being offered for a further **year** by the **Society** at the **renewal date**, the **policy** may be renewed by the **policyholder** paying the **premium** requested and the **Society** accepting such renewal. By renewing the **policy**, the **policyholder** undertakes to accept the rules and conditions of the **policy** which apply at the **renewal date**.

2.8 The **Society** may place special terms on the **policy** including, but not limited to, the following:

- exclusions of specific medical conditions
- restrictions on particular **benefits** and
- discounts or surcharges on the published **premium** rates.

Any such special terms will be confirmed in writing by the **Society** at the time of joining or renewal.

### 3. Changes to Cover

3.1 In normal circumstances changes from one **plan** to another, a change of level within a **plan** or any change to the level of **excess** can only be effected at the **renewal date**. Changes to cover at any other time during a **year** may be allowed at the sole discretion of the **Society**.

3.2 In the event of a change to a different level of cover and/or **excess**, the **benefits** payable for

any eligible medical conditions in existence prior to the change, will be restricted to either the **benefits** available when the medical condition originated or the level applicable at the date of any **treatment**, whichever is lower.

3.3 **Members** may apply to increase their level of cover up to the **renewal date** immediately after their seventy-ninth birthday.

3.4 The **Society** is entitled to refuse a change from one **plan** to another without providing a reason.

3.5 If a **member** changes to one of the Society's plans under which premiums are calculated according to age on entry, the Society will use the member's age at the date of such change in order to calculate the premium payable.

### 4. Premiums

4.1 The **Society** will determine the amount of **premium** payable at the start of each **year** and will advise the **policyholder**. **Premiums** must be paid to the **Society** in euro for the whole **year** in the manner agreed at that time.

4.2 The **Society** may alter the amount of **premium** payable during a **year** to reflect any change in Insurance Premium Tax or other government taxes or levies, but will inform the **policyholder** at least 14 days before the changes become effective.

4.3 **Premiums** are due in advance and must be paid immediately they become due. No **member** in arrears with his **premium** is entitled to make a claim or receive any

**benefits**, and the **Society** will cancel any **policy** on which the **premium** is overdue. A **member** may cancel his **policy** within 14 days of receiving his documents or within 14 days after the date risk starts if later, and a refund of **premiums** will be paid less an allowance for the period the **policy** has been on risk calculated on a pro rata basis. If the **member** or the **Society** cancels a **policy** at any other time, **we** will have the right to retain or demand all or part of the **premium** as a contribution towards any costs the **Society** has incurred.

4.4 In order to comply with money laundering regulations, the **Society** may ask the **policyholder** to provide proof of identity for the payer of the **premium** and for any of the **members** included on the **policy**.

4.5 In the event of the death of a **member**, and providing that the **Society** is notified within six months of the death, the **Society** will make a pro-rata refund of the **premium** already paid which relates to the period after the date of death.

## 5. Claims

5.1 A **member** proceeds at his own financial risk if he does not contact the **Society** and obtain pre-authorisation prior to the commencement of any **treatment**, except for **treatment** received in an emergency admission.

5.2 The **Society** will only consider a claim if:

- a **member** is up-to-date with his **premium** payments

- any outstanding invoices received by the **member** have been submitted to the **Society** within three months of the date of **treatment** and
- the **Society** has been given any additional information (including medical information) requested from the **member** and from any person who has provided or proposes to provide any of the services that are the subject of the claim.

5.3 Even though the **policy** is subject to an **excess**, claims should be submitted in accordance with rule 5.2 regardless of whether or not the eligible expenses are less than the **excess** amount.

5.4 The **member** must inform the **Society** immediately if any of the expenditure can be claimed, or might be claimed, from anyone else or from any other insurance policy (see rule 6.9).

## 6. Benefits

6.1 The **Society** will pay those **benefits** entitled to be claimed under the **policy** in accordance with the Policy Rules current when the **member** incurred the expenditure (except in circumstances where rule 3.2 applies). Payment can only be made to the service provider or the **policyholder** and not to any other party. If for any reason those **benefits** do not cover the full costs incurred, the **member** will be liable to pay the balance.

6.2 The **Society** will refund only those medical expenses that, in the **Society's** opinion, are

*reasonable*, eligible, *customary* and necessarily incurred.

6.3 *Benefits* will be paid in accordance with the *member's* level of cover and will not exceed the amount of actual expenditure incurred. *Benefits* cannot be transferred to any other *member* or be carried over to any other *year*.

6.4 The contract for the provision of medical and ancillary services in respect of which *benefits* are paid is between the *member* and the relevant service provider. Notwithstanding that *we* may or do pay on your behalf some or all of the *benefits* directly to the service provider, the *benefits* are intended to indemnify you in respect of all eligible costs of the *treatment* in accordance with your *plan*. The primary liability to pay the service provider remains with the *member*.

6.5 EuroHealth Plan is subject to a compulsory *excess*, which applies to each *member* every *year*. Therefore, the *Society* will not pay *benefits* until:

- the *member* has had *treatment* during the *year* which is eligible for *benefits* and
- the amount of the eligible expenses exceeds any *excess* amount

By 'eligible expenses' *we* mean any expenses that would have qualified for *benefits* had any *excess* not been in place. The amount of any *benefits* claimed for *treatment* that would have been payable but for the *excess* shall nevertheless count towards the *benefit* limits contained within the table of *benefits*. If the *treatment* spans two *years* any *excess* will be applied in each *year*.

6.6 *Benefits* are only available for *treatment* received in Portugal, Spain or the United Kingdom.

6.7 Entitlement to *benefits* will be assessed in euro. If a claim is made in a different currency, the *Society* will convert the expenditure incurred into euro, using the exchange rate at which the *Society's* international bankers buy the currency at the time the claim is assessed.

Claim settlements will be paid in euro.

*Members* may request that settlements be paid in a different currency and the *Society* may, at its discretion, agree to provide this additional service. In these circumstances the *Society* will convert the *benefit* entitlement from euro using the exchange rate at which the *Society's* international bankers sell the currency at the time the claim is paid.

The *Society* will pass on to the *member* any bank charges incurred in handling different currencies.

Any differences arising from exchange rate movements or from the spread between the buying and selling exchange rates will be the *member's* responsibility. Note that the buying rate is always greater than the selling rate and this difference means that if expenses are incurred in a currency other than euro, they are unlikely to be completely covered by the *benefits* paid, even when all of the expenses are eligible for *benefit*.

6.8 In the event of the death of a *member*, the *Society* may pay any *benefits* due to the following:

- appropriate service providers

- the deceased's personal representatives
- any other person covered by the **policy**, as the **Society**, at its discretion, shall determine.

6.9 The **member** must inform the **Society** if any of the cost can be claimed from anyone else or under another insurance policy. If it can, the **Society** will only pay its proper share.

6.10 Where any **treatment** arises as a result of an injury, or disease for which a third party is, or may be liable, the following provisions shall apply:

- The **member** shall inform the **Society** at the time the claim is made, of the name and address of the third party and whether damages are to be claimed from the third party by the **member** or on his behalf.
- Where the **member** or someone on his behalf is to claim damages from a third party and in consideration of the **Society** agreeing to provide **benefits** under this clause, such person will be required to sign an undertaking; full details to be issued by the **Society** at the time.
- Where the **member** does not intend to pursue a claim for damages against the third party, he shall authorise the **Society** at its own expense to pursue a claim in his name against the third party for the **benefits** paid by the **Society** in respect of such **treatment**, and shall co-operate fully with the **Society** in pursuing such claim including (where necessary) attending court to give evidence as to the circumstances in which the claim against the third party arose.

- Provided the **member** has complied in good faith with the terms of this clause, the **Society** shall only be entitled to recoup from the **member** sums paid in respect of **benefits** so far as such **benefits** are recovered from the third party. Where liability for the incident is apportioned, the **Society** shall be entitled to a pro-rata proportion of the **benefits** paid.
- The **member** shall not be entitled to **benefits** save in accordance with the provisions of this clause. Where the **Society's** right to recoup **benefits** from the **member**, or to recover **benefits** paid to the **member** by any third party, has been prejudiced by the **member's** failure to comply with the terms of this clause, the **Society** shall be entitled to recover such **benefits** from the **member** or from the **policyholder**.

By third party **we** mean any person or corporate body other than the **Society** or the person who has received **treatment**.

## 7. Underwriting Terms

Please note; you will need to refer to your **Policy Certificate** for confirmation as to whether 7.1 (a) or 7.1 (b) applies to the persons covered by your **policy**.

7.1 (a) Where the **member** completed a medical history declaration when applying to join the **Society** (fully underwritten):

**Benefits** are not payable in respect of any symptoms or medical condition that the **member** already had, or which was foreseeable when the **member** joined; nor for

the recurrence of any previous symptoms or medical conditions, unless full particulars were disclosed on the application for the **policy**, or subsequently disclosed and accepted for **benefits** by the **Society**.

7.1 (b) Where the **member** was subject to moratorium terms when joining the **Society** (applicable to transfers only):

**Benefits** are not payable for the investigation or **treatment** of symptoms or a medical condition for which the **member** received advice, medication, tests or **treatment**, or was aware of, or might reasonably have been aware of, in the five years prior to joining the **Society**. Once the **policy** has been effected, such conditions may automatically become eligible for cover provided there has been no recurrence of symptoms, or the need for advice, medication, tests or **treatment** (from the patient's medical practitioner or any **specialist**) for such conditions or any related conditions, for a continuous period of two years. In the event of symptoms or a medical condition that existed in the five years prior to joining the **Society** recurring during the first two **years** of the **policy**, a further two 'clear' **years** must elapse before the condition can be considered for **benefit** entitlement.

## 8. Benefit Exclusions

**Benefit** shall not be paid in respect of:

(a) Primary care services, or services which have been provided by a **specialist** acting in the capacity of a primary carer or carrying out primary care services unless the plan provides such benefits.

(b) **Chronic conditions** following the initial diagnosis and therapy.

(c) **Treatment** of any orthodontic, periodontal, dental condition or prosthetic dental work.

(d) Charges for **treatment** incurred in nursing homes, health hydros, spas, nature cure clinics or any similar establishments.

(e) Any treatment of obesity.

(f) Convalescence and/or rehabilitation.

(g) **Treatment** or investigations required because of or in connection with:

- pregnancy or child birth
- male or female birth control
- abortion
- any form of assisted reproduction such as in vitro fertilisation
- impotence
- infertility.

(h) **Treatment** relating to congenital and hereditary conditions.

(i) Preventive screening procedures and tests. These include screening procedures as a result of poor personal or family history, smears, mammograms, well-person health checks, vaccinations, immunisations and osteoporosis screenings.

(j) Out-patient drugs and dressings.

(k) Surgical appliances and/or **orthoses** together with any charges incurred for the measuring and fitting thereof.

(l)

- Cosmetic or reconstructive **treatment**, or any **treatment** which relates to or is

needed because of previous cosmetic or reconstructive surgery.

- Breast enlargement or reduction, whether or not needed for psychological or medical reasons including, but not limited to, backache.

**Benefit** may be available for **treatment** to restore your appearance after an accident, or as a result of surgery for cancer, providing that this is part of the original **treatment** for the accident or cancer, and that the accident or cancer occurred during your current continuous **policy**. You must, however, obtain **our** written agreement before receiving **treatment**.

(m) Hormone Replacement Therapy and directly related conditions.

(n) **Treatment** that arises from or is in any way connected with excess alcohol intake or drug or substance abuse.

(o) Regular or long-term renal dialysis in chronic or end-stage kidney failure.

(p) Transplant operations, including investigations done before the operation, or **treatment** needed as a result of the operation. **We** will, however, cover cornea and skin grafts.

(q) **Treatment** directly or indirectly arising from or consequent upon war, invasions, acts of foreign enemies, hostilities (whether war be declared or not), terrorism, civil war, riot, civil disturbance, revolution, insurrection, or military or usurped power.

(r) **Treatment** for Acquired Immune Deficiency Syndrome (AIDS) and all diseases caused by HIV.

(s) **Treatment** for sexually transmitted diseases.

(t) **Treatment** for, or which arise from, sex change.

(u) **Treatment:**

- for depression and/or
- for stress and/or
- for mental illness and/or
- for psychiatric disorders and /or
- for psychological disorders and/or
- which arises from, or is in any way attributable to, wilfully self-inflicted injury or attempted suicide.

(v) Any intensive care except that consequent to the **treatment** of medical conditions or surgical procedures which have been pre-authorised by the **Society**.

(w) **Treatment** which arises from, or is in any way attributable to, injuries sustained as a result of participating in **professional sports** or hazardous sports or activities, including but not limited to the following: motor racing, mountaineering, parachuting, pot-holing, private aviation or rock climbing.

(x) **Treatment** in a nursing home or hospital which has effectively become the place of domicile or permanent abode.

(y) **Treatment** or drug therapy which in the **Society's** opinion is experimental and/or unproven having taken consideration of current National Institute for Clinical Excellence (NICE) guidelines.

(z) **Treatment** received outside Portugal, Spain or the United Kingdom except with the prior agreement of the **Society**. **Please Note: We** do not cover any **treatment** received in the U.S.A. or Bahamas.

## 9. General

9.1 The terms of the **policy** may be varied at any time by the **Society**, such terms include the following:

- the level of **premium** and the terms on which it is paid
- the **benefits** provided and the terms on which they are provided.

The **Society** may also withdraw or cancel any **plan** at any time. The **Society** will give **you** reasonable notice of such changes by posting details to the address last shown for the **policyholder** on the **Society's** records. However, the changes will take effect even if the **policyholder** does not receive notification for any reason.

9.2 If any dispute shall arise between the **member** and the **Society**, they shall use the **Society's** complaints procedure to resolve it. If any **member** brings details of any dispute with the **Society** into the public domain prior to exhausting the **Society's** complaints procedure, then the whole **policy** under which **benefits** are payable in respect of them will be cancelled.

9.3 If any **member** breaks any of the terms of the **policy** or makes, or attempts to make, any dishonest application or claim, the **Society** shall be entitled to:

- refuse to pay any **benefits** and
- cancel the **policy** immediately.

9.4 In certain circumstances the **Society** has the right to cancel a **policy** at any time, for reasons including but not limited to the following:

- if a **member** brings disgrace on the **Society**
- has failed to act with utmost good faith, or
- is abusive to staff

The **Society** will always give reasonable notice of such a course of action.

9.5 When dealing with the **Society**, a **policyholder** acts on behalf of every **family member** included on his **policy**.

9.6 The **policyholder's** address will be used for all correspondence in respect of the **family members** on his **policy**, unless otherwise agreed by the **Society**. The **policyholder** must therefore immediately advise the **Society** of any change of address.

9.7 Your **policy** is governed by English law. Any dispute that cannot otherwise be resolved will be dealt with by courts in the **United Kingdom** or in your country of residence.



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— Society —

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