



EuroMedical

Policy Document

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EuroMedical is arranged by

ibex
INSURANCE

Private Medical Insurance
underwritten & administered by



Exeter Friendly
— Society —

Contents

Introduction	2
Definitions	3
Language Used & Law Applicable	6
Demands & Needs Statement	6
Important Notes For New Policyholders	7
Age At Entry Pricing Explained	7
Paying Your Premium	9
Renewing Your Policy	10
Cancelling Your Policy	10
Excesses	11
A Guide To Making A Claim.....	15
Table Of Benefits	16
Chronic Conditions	18
GP Helpline	21
Our Standards	21
If You Are Not Satisfied	21
Financial Services Compensation Scheme (FSCS)	22
Data Protection	23
Policy Rules	24

Introduction

Thank you for choosing EuroMedical, a private medical insurance plan arranged by Ibex Insurance and underwritten 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](tel:+441392353500) or contact your local Ibex advisor, who will be happy to help you. The information in this Policy Document is valid only for cover from 1 January 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**.

Excess

An amount of eligible **benefit** that is waived by a **policyholder** for each **member** in a **year** in return for a reduced **premium**.

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, plus **diagnostic tests** ordered by the GP.

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

EuroMedical meets the demands and needs of a person who is resident in Portugal or Spain, or resides in more than one EEA country, 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 EuroMedical 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**.

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 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 **lbex 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.

Age At Entry Pricing Explained

Introduction

EuroMedical is priced on an "Age at Entry" basis; "The age you join is the age you stay". The purpose of this section is to explain:

- what this approach means for you in practice
- the assurances that are being offered
- what is guaranteed and what is not.

Brief summary

Put simply, the **Society's** approach means that your **premium** will not increase solely because you (as an individual) get older, provided that your cover remains unchanged. Your **premium** is determined by the age at which you joined the **Society**, rather than your age at each renewal (see "Dependent Children" on page 10) for an explanation of how this is applied to any

children included on your **policy**.

It does not mean that your **premium** will not increase at all. Indeed the expectation is that your **premium** is likely to increase **year-on-year** because of a variety of factors (see "Factors influencing **premium** rates" below) and generally at a rate greater than retail price inflation. However, the **Society's** policy means that your **premium** should rise more gradually as you get older because it will only move in line with the increases required to keep the **plan** as a whole on a sound financial footing and not because your age increases.

In general the cost of Private Medical Insurance increases significantly with age and with most insurers your **premium** would rise more rapidly as you got older.

take precedence over the approach outlined in this section.

What is guaranteed?

The **Society** guarantees that your **premium** in any future **year** will always be calculated with reference to the age at which you joined the **Society**, for as long as you remain a **member** of the same **plan** with the same cover (including any optional **excess**). This means that you will pay a lower **premium** than an otherwise identical **member** on the same **plan** and level of cover, provided you joined at an earlier age.

If your **plan**, **excess** or level of cover is changed, the **Society** may change the age on which your **premium** is based.

What is not guaranteed?

The **Society** does not guarantee the level of **premium** that you will be charged in future **years**. Within the constraints set out in the previous section, the **Society** has complete discretion to alter the **premium** rates for a particular **plan** and level of cover.

The **Society** does not guarantee the level or continuing existence of any discounts that may have been granted in the past.

The **Society** will be guided by the need to ensure its continued financial well-being and to meet statutory levels of solvency. This need will, if necessary,

What if I change my cover?

In general, if the **Society** considers that the extent of your cover is reduced then you will be allowed to remain on your original age at entry (provided that the **plan** to which you are transferring is also age-at-entry). However, if the **Society** considers that the extent of your cover has been increased then you will normally be "re-age-rated", i.e. your new **premium** will be calculated with reference to your age at the time of the change. In this context the **Society** may consider any of the following to mean an increase in cover: a change to a **plan**, or level within a **plan**, that offers higher **benefits**, and/or a reduction in the amount, or removal, of an optional **excess**.

This is because the age-at-entry pricing structure that the **Society** operates relies on an element of pre-funding and cross-subsidy; i.e. some of the **premiums** that you and other **members** pay in the early **years** of your **policies** will contribute to a reserve set up to meet claims arising in the later years of those **policies**.

However, if you increase your level of cover then the **premiums** that you will have contributed to the reserve will not reflect the expected future claims under your increased level of cover. Therefore, in order to ensure fairness to other **members**, the **Society** "re-age-rates" **members** when the extent of their cover is increased.

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**
- 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.

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 their **premium** will initially be calculated by reference to the rate applicable to a 21 year-old **policyholder**, and will remain calculated according to that age, unless of course they subsequently break and/or change their cover (see “Age At Entry Pricing Explained” on page 7)

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

If **you** have chosen to take out an **excess** on your **plan**, this will be shown on your **Policy Certificate**. This means that **you** have agreed to waive entitlement to any **benefits** to which you would otherwise have been entitled, up to the value of the **excess**, for each **member** included on your **policy**.

We apply any **excess** to each person on the **policy** each **year** if you claim. 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 an **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 the **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.

We currently offer discounts of:

- 5% for a €150 **excess**
- 10% for a €300 **excess**
- 15% for a €500 **excess**
- 20% for a €750 **excess**
- 25% 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 Two cover with an **excess** of €150. Her **policy** runs from 1 March each **year**. In July, she is referred to a **specialist** and her claim is approved by **us**. The **specialist** charges her €80. This is her first eligible charge in this **year**. As she has an **excess** of €150, 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 **specialist** charges €80 each time. **We** will pay €90 towards the cost of these charges. **We** will then write to Margaret to advise her that she needs to pay the remaining €70, because of the outstanding amount on her **excess**.

In October, Margaret is referred to a **specialist** for a different medical condition, and sends **us** an invoice for a further €80. As the **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 €140 from the amount payable to cover the remaining **excess** for the first **year**. However, **we** will then deduct a further €300 in order to cover the **excess** for the second **year**. **We** will therefore pay €1,960 to the hospital and Steven will need to pay the outstanding amount of €440.

	Year 1	Year 2
	€	€
Excess	300.00	300.00
Already paid	160.00	-
Excess still to pay	140.00	300.00

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

Remaining excess payable by Steven (Year 1) €140

EuroMedical Table Of Benefits

This table shows the **benefits** which apply to each person covered under these **plans** each year and the particular terms of your own **policy**.

	Three	Two	One
Overall Maximum Benefit	€550	€450	€270
In-Patient & Day-Patient Benefits			
Hospital Charges	€55,000 per condition, per year and within the Overall Maximum Benefit	€32,500 per condition, per year and within the Overall Maximum Benefit	€8,000 per condition and within Overall Maximum
Specialist Services	Paid in Full*	Paid in Full*	Paid in Full*
Pre-Admission Tests	Paid in Full*	Paid in Full*	Paid in Full*
Parental Accommodation (For children under the age of 12 years) † See notes	Paid in Full*	Paid in Full*	Nil
Out-Patient Benefits	Three	Two	One
Out-Patient Services	€4,000	€2,500	€2,500
Complementary Treatment (Such as physiotherapy, osteopathy & chiropractic)	per year	per year	per year
Additional Benefits	€1,250	€600	€225
Oncology	per year	per year	per year
Home Nursing	Three	Two	One
Private Ambulance	€55,000 per year	€30,000 per year	€15,000 per year
Primary Care	€1,300 per year	€800 per year	€320 per year

***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

Year. Please remember that your being able to claim these **benefits** will depend on our rules

Plus	One	Notes
75	€275	The total benefit available per year for each person included on the policy
00	€8,000 per condition, per year and within the Overall Maximum Benefit	Notes
Full*	Paid in Full*	Includes accommodation , nursing, theatre fees & consumables, surgical
Full*	Paid in Full*	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.
l	Nil	drugs & dressings, diagnostic tests , scans, physiotherapy, pathology & eligible prostheses whilst you are an in-patient or day-patient.
Plus	One	Surgeon's, anaesthetist's and physician's fees for in-patient treatment &
00	€1,500	day-patient treatment .
ear	per year	For one parent/guardian accompanying a child named on the Policy Certificate who is admitted as an in-patient. This benefit is payable towards accommodation only. Visitors' meals, telephone calls,
25	€225	newspapers etc are not included. †This benefit is not payable where the
ear	per year	hospital provide a relative's bed free of charge.
Plus	One	Notes
000	€3,000 per year	For specialist consultations, minor surgery, diagnostic tests , x-rays and scans.
25	€325 per year	Treatment must be carried out by a doctor or practitioner who holds a certificate of specialist training recognised by the Society .

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**.

Excess payable by Steven (Year 2)

€300

Total excess payable by Steven
(€440)

Remaining amount payable by us
€1,960

Example 3

Mary has Level One cover with an **excess** of €300. 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 €225 per **year** for physiotherapy. This means that only €225 of the €350 **treatment** costs are eligible for **benefit**. However, as Mary also has an **excess** of €300 on her **policy**, **we** will then deduct this from the €225, 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 €75 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 no **excess** been chosen, together with the amount payable with the **excess**.

No Excess
€250 excess

€

€

Total of Invoices

350.00

350.00

Benefit available

225.00

225.00

Excess deductible

0.00

300.00

Amount payable by us

225.00

0.00

Amount payable by Mary

125.00

350.00

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 €75 being deducted from the amounts claimable for the **year**.

Example 4

Catherine has taken out Level Two cover with an **excess** of €750, 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 €750 from this to cover the **excess**, and will pay the remaining €750.

In March, Catherine is also admitted to hospital and the **treatment** costs €2,600. Because the **excess** is applied to each person on the **policy** each **year** if an eligible claim is submitted, **we** will deduct Catherine's **excess** of €750 and pay the remaining €1,850.

Example 5

David has Level OnePlus cover with an **excess** of €300. He sends **us** invoices for osteopathy totalling €500. The maximum **benefit** claimable by David for osteopathy is €225, therefore this is the maximum amount he can offset against his **excess** for the current **year** and the full €500 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 no **excess** been chosen, together with the amount payable with the **excess**.

No Excess
€300 excess

€
€

Total of Invoices

500.00

500.00

Benefit available

225.00

225.00

Excess deductible

0.00

300.00

Amount payable by us

225.00

0.00

Amount payable by David

275.00

500.00

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 **excess** amount of €75 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 **excess** with effect from your **renewal date**. If **you** increase your level of **excess**, **we** will apply your new higher **excess** to any claims you make after your **renewal date**.

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

Here are some examples of how this works:

Example 1

Sarah has an **excess** of €300. Her **renewal date** is 1 June, and after a **year** of having the **policy** she decides to increase this **excess** to €750. In September, she makes a claim. **We** will apply her new **excess** of €750.

Example 2

Tom has an **excess** of €750. His **renewal date** is 15 August and he decides to reduce his level of **excess** to €300. 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 €300, as this is a new condition.

Example 3

Sheila has an **excess** of €750. Her **renewal date** is 1 February, and she decides to reduce her **excess** to €300. 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 €750, 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**. 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.

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. **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 you have an **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. Please note, however, that **we** do not consider cancer to be a **chronic condition**.

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 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 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 enquires, 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 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 indefinitely 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).

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**.

Private Medical Insurance
underwritten and administered by



Exeter Friendly
Society

Exeter Friendly Society Limited
Lakeside House, Emperor Way, Exeter. EX1 3FD. United Kingdom

Website: www.exeterfriendly.co.uk

Telephone calls may be recorded and monitored for quality assurance and training purposes.

Exeter Friendly Society Ltd is incorporated in England under the Friendly Societies Act 1992,
registered number 91F, registered address as above.

Authorised and regulated by the UK Financial Services Authority, registered number 205309.



INVESTOR IN PEOPLE

**ALL DOCUMENTS ARE AVAILABLE IN LARGER TEXT PLEASE CONTACT CUSTOMER
SUPPORT ON +44 1392 35 35 00 WITH YOUR REQUIREMENTS.**

EuroMedical Private Medical Insurance is arranged by

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INSURANCE

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The Tower, Marina Bay, Gibraltar.

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