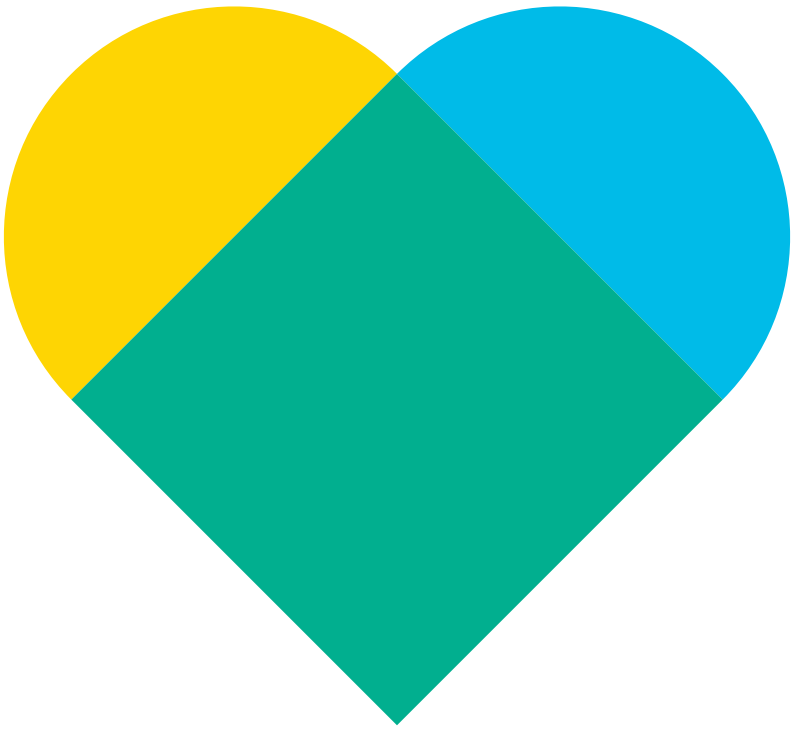
Health Choices for Me

Policy Document



The Exeter

Protect tomorrow today.

Definitions

Where you see the following words used in this document, please refer to these definitions to find out exactly what they mean.

Acute
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.

Adult
Someone who is 18 years or older.

Benefit
The amount that may be payable by us for any eligible claim.

Cancer
A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Chronic condition
A disease, illness or injury that has one or more of the following characteristics:

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- It needs ongoing or long-term control or relief of symptoms
- It requires your rehabilitation or for you to be specially trained to cope with it
- It continues indefinitely
- It has no known cure
- It comes back or is likely to come back.

Day-patient
A patient who is admitted to a hospital or day patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.

Dependant
Any child for whom you or your partner holds or has held the position of a legal guardian.

Diabetes
We use the term Diabetes to refer to the condition of Diabetes Mellitus, which occurs due to insulin resistance or insulin deficiency and results in the body's inability to regulate blood glucose levels. We do not include the rarer, unrelated condition of Diabetes Insipidus which is a disease of excessive urination not linked to blood sugar levels.

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

Excess
The amount which will be deducted from the eligible benefits for each person, each policy year. Health Choices for Me includes a £100 compulsory excess and you can choose to add a voluntary excess to your compulsory excess to reduce your premiums.

Fee Schedule
This sets out the maximum fees we will pay specialists for the treatment they provide to our members. This list may change; the most up-to-date list is available on our website.

Heart condition
A disorder of the heart that impairs its function. For illustration, the most common conditions falling into this definition are:

- Ischaemic heart disease (angina, heart attacks, coronary artery disease)
- Valvular heart disease (adult murmurs, valve narrowing or weakness)
- Congenital heart disease
- Arrhythmias (irregular heartbeat)
- Cardiomyopathy
- Left ventricular hypertrophy (LVH).

However, we do not include heart murmurs that were resolved in childhood or hypertension in this definition.

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

Hospice
A dedicated facility for patients with an advanced progressive incurable disease, which attends to the physical, psychological and spiritual needs of the patient and those close to them.

Hospital List
The list of hospitals and clinics in the United Kingdom covered by your policy. This list often changes, so you should always check with us before arranging treatment. The most up-to-date list is available on our website.

In-patient
A patient who is admitted to hospital and who occupies a bed overnight or longer for medical reasons.

Membership Benefits
Alongside the benefits we provide under this policy, we seek to enhance your experience by providing you with membership benefits which do not form part of the terms of this insurance policy. Because of this they may be varied or withdrawn without notice by us.

Details of the membership benefits we currently offer are available on our website.

Medical aids
Additional equipment designed to be used externally, e.g. shoe inserts, neck supports and wrist braces. Equipment must be for the purpose of aiding recovery rather than managing long-term conditions.

Non-smoker
Someone who has not smoked or used nicotine replacement products in the last 12 months.

Nurse
A qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.

Out-patient
A patient who attends a hospital, consulting room or out-patient clinic and is not admitted as a day-patient or an in-patient.

Plan
Health Choices for Me.

Policy
Our contract of insurance with you.

Policy Certificate
The document we issue that includes details of your cover and any personal restrictions that apply to your plan. To be read in conjunction with this document.

Policyholder
The person who has taken out the policy as detailed on the Policy Certificate.

Pre-existing condition
Any disease, illness or injury, for which:

- you have received medication, advice or treatment; or
- you have experienced symptoms;

before the start of your cover, whether or not the condition has been diagnosed.

Premium
The amount payable to us by the policyholder as detailed on the Policy Certificate.

Renewal date
The date on which the policy is renewed and as detailed on the Policy Certificate.

Specialist
A registered healthcare professional who must hold the appropriate qualifications and be on the GMC specialist register and must belong to a recognised professional regulatory body.

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
The Exeter, a trading name of Exeter Friendly Society Limited.

Year
A period of 12 calendar months from renewal date or policy start date as detailed on the Policy Certificate.

You/Your
Anyone included on the policy and named on the Policy Certificate.

Contents

Welcome to Health Choices for Me

Health Choices for Me allows you to benefit from quick access to quality private treatment in a way that suits your needs and budget.

This document contains the terms and conditions of your policy - please read it with your Policy Certificate for full details of cover.

Please take the time to read through this document

To help, we have signposted certain key information with the following symbols:

indicates information we've highlighted that you may find useful

indicates guidance and examples to explain how the policy works in practice

Words underlined in yellow or white indicate a signpost to another part of the document or a separate brochure.

Cover and benefits

Health Choices for Me is a simple, modular health insurance plan. This section explains the cover provided by Health Choices for Me and the options to personalise your cover.

Essential cover

The table below shows the Essential Cover that your membership gives you - you should read this alongside the other sections of this document, particularly 'Definitions' and 'Making a claim', together with 'Will treatment charges be paid in full?', 'Excesses'and 'Exclusions' that appear later in this section.

Please note that with the exception of the £250 hospice donation, no benefit will be paid for diagnosed cancer conditions under Essential Cover. This is because cancer cover is available as a separate option - see 'Cover options' over the page.

What can you claim for?	What does this include?	How much will we pay?
In-patient and day-patient treatment	Consultant & specialist fees, diagnostic tests as an in-patient or day-patient, pre-admission tests and hospital charges (including any necessary medical aids or take-home drugs) at any hospital on the Hospital List.	✓ Unlimited
CT, MRI & PET scans	CT, MRI or PET scans, at any hospital on the Hospital List. Includes professional fees where appropriate.	✓ Unlimited
Out-patient surgery	Surgical procedures performed by a specialist at any hospital on the Hospital List.	✓ Unlimited
Private ambulance	Medically essential travel to, between or from hospital in a private road ambulance in connection with in-patient or day-patient treatment.	✓ Unlimited
Home nursing	Home nursing following authorised in-patient and day-patient treatment.	✓ Unlimited
Parental accommodation	You can stay in hospital with your child (up to the age of 18) if they are having treatment under the policy.	✓ Unlimited
Post-operative physiotherapy	Post-operative physiotherapy as an out-patient following in-patient, day-patient or out-patient surgery.	Up to 3 sessions
NHS Cash benefit	Paid if you have free in-patient treatment under the NHS that would be covered under your policy.	£250 per night
Hospice donation	We make a donation to your hospice if you are admitted for care.	£250

Cover options

The table below shows the options to personalise your cover.

The options you currently have will be shown on your Policy Certificate.

Cover Module	What does this include?	How much cover - your options
Out-Patient	Consultant and specialist fees. Diagnostic tests such as X-rays, ECGs and pathology tests at any hospital on the Hospital List. Please note that CT, MRI and PET scans are included as standard under Essential Cover. No benefit for diagnosed cancer conditions as these are included in the optional Cancer Cover module below.	▸ Unlimited ▸ Up to £1,000 per year ▸ Up to £500 per year ▸ No Cover
Cancer Cover	Extends the scope of benefits under Essential Cover (such as surgery and scans) to include unlimited benefit, treatment and specialist consultations for diagnosed cancer. For more details go to the Cancer Cover section on page 7.	▸ Unlimited ▸ No Cover
Manipulative Treatment	Costs for physiotherapy, osteopathy, podiatry and chiropractic treatment received as an out-patient.	▸ Unlimited ▸ Up to £300 per year ▸ No Cover

All you need to remember before going ahead with any tests or treatment is to contact us on **0300 123 3253** and we will guide you through the claims process.

Approved treatment requires a referral from your GP and will only be eligible at a hospital on the Hospital List.

Benchmark for eligible treatment

We use NICE (National Institute for Health and Care Excellence) as our main benchmark for deciding whether treatment and drugs are eligible under Health Choices for Me. NICE is responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

Treatments that have been approved by NICE for clinical effectiveness are eligible, regardless of any decision by NICE relating to cost effectiveness. Treatments that have not been approved by NICE for clinical effectiveness are not covered under this plan.

Will treatment charges be paid in full?

Whether your treatment charges will be paid in full will depend on two factors.

Firstly, what is covered by your Health Choices for Me policy and to what level is dependent on the choices that you made with your application. For example, if you choose to limit out-patient cover to £500 per year and then make a claim for £600 of out-patient consultations on a back injury, this isn't covered in full.

Secondly, we want to ensure that the fee a specialist charges for any claim you make is within the limits we will pay.

We publish a fee schedule, which sets out the maximum fees we will pay specialists for the treatment they provide to you. It is therefore important that you follow our claims process detailed on page 22.

If the specialist fee exceeds the maximum shown in our fee schedule, we will tell you how much we will pay towards the cost of your treatment. In this case you will have to pay the remainder of the fee yourself, this is commonly known as a shortfall.

To see our most up-to-date fee schedule, please visit www.the-exeter.com/feeschedule or contact us on 0300 123 3253.

Cancer Cover

We know that for many customers, cancer cover is an important feature of their private medical insurance; but equally some customers are happy to rely on the NHS and the cancer treatment it provides.

As a result, Health Choices for Me offers the choice of whether or not to include cancer cover in your policy. The option you currently have will be shown on your Policy Certificate.

Whether or not your policy includes the cancer cover option, any initial consultations and tests leading to the diagnosis of cancer would be covered under the Out-Patient module (if selected) or Essential Cover in the case of scans or in/day-patient procedures. Please see Essential cover on page 4 for scans covered.

From this point on, the cover differs in the following ways:

If your policy does not include the cancer cover option

Once a cancer condition has been diagnosed, you are not covered for any treatment, monitoring or any further diagnosis related to the cancer under your Health Choices for Me policy. Instead, you will need to be referred to the NHS for treatment.

If your policy includes the cancer cover option

You will be covered for all stages of cancer once diagnosed - as summarised over the page. Please note that cancer cover is also subject to the general terms and conditions of this plan, in particular the section 'Will treatment charges be paid in full?'.

Cancer cover

	What cover is available with the cancer cover option?
Place of treatment	**Full cover** for treatment at any hospital on the Hospital List and chemotherapy at home
Diagnostic	**Full cover** for specialist consultations, tests & scans after the cancer has been diagnosed. Consultations, tests and scans to establish a diagnosis would be covered under the Out-Patient module (if selected) or Essential Cover in the case of scans or in/day-patient procedures
Surgery	**Full cover** for surgery, including the removal of a tumour and any consequent reconstructive surgery that you need, at any hospital on the Hospital List
Drug therapy	**Full cover** for all types of drug therapy for your cancer, including chemotherapy & drugs to maintain any remission, providing they have received NICE approval for clinical effectiveness
Radiotherapy	**Full cover** for radiotherapy including when it is given for pain relief
Palliative	**Full cover** for treatment aimed at controlling the symptoms of cancer or relieving pain rather than curing the cancer
End of life care	**£250 donation** to a hospice if you are admitted for care. **Full cover** for care of terminal cancer at any hospital on the Hospital List while you are awaiting admission to a hospice
Monitoring	**Full cover** for follow up reviews related to the continuing care of your cancer, including when in remission
Limits	**Unlimited.** We do not place any specific time or financial limits on cancer treatment
Preventative	**No cover** for preventative screening, treatment or vaccines
	Other benefits:
Stem cell or bone marrow treatment	**Full cover** for bone marrow and stem cell transplants, provided they are not experimental
Hormone therapy	**Full cover** for hormone therapy needed during cancer treatment
Cash benefit	**£250 per night** if you have free in-patient treatment for cancer under the NHS that would otherwise have been covered under your policy

Examples of how cancer cover works in practice

The following pages show examples of how cancer cover works in practice.

It is important to note that you will only be eligible for treatment at a hospital on the current Hospital List and we will only pay treatment charges in full if specialist fees are within those detailed on our fee schedule.

To see our most up-to-date fee schedule, please visit www.the-exeter.com or contact us on **0300 123 3253**.

Any benefits payable will be subject to the excess that applies to your policy.

Beverley's policy includes the cancer cover option. She has been with The Exeter for five years when she is diagnosed with breast cancer.

Following discussion with her specialists she decides:

- to have the tumour removed by surgery. As well as removing the tumour, Beverley's treatment will include a reconstruction operation
- to undergo a course of radiotherapy and chemotherapy
- to take hormone therapy tablets for several years after the chemotherapy has finished

Will her policy cover this treatment plan and are there any limits to the cover?

Providing Beverley has pre-authorised the claim with us, we will pay for the consultations, operations and breast reconstruction. Crucially, we will pay for all radiotherapy, chemotherapy and hormone therapy that are needed to treat the cancer on an ongoing basis.

During the course of chemotherapy Beverley suffers from anaemia. Her resistance to infection is also greatly reduced.

Her specialist:

- admits her to hospital for a blood transfusion to treat her anaemia
- prescribes a course of injections to boost her immune system

Will her policy cover this treatment plan and are there any limits to the cover?

We will pay for the blood transfusion and course of injections.

Despite the injections to boost her immune system, Beverley develops an infection and is admitted to hospital for a course of antibiotics.

Will her policy cover this treatment and are there any limits to the cover?

We will pay for the admission to hospital and for the antibiotics.

Five years after Beverley's treatment finishes the cancer returns. Unfortunately, it has spread to other parts of her body.

Her specialist has recommended a treatment plan:

- A course of six cycles of chemotherapy aimed at destroying cancer cells to be given over the next six months
- Monthly infusions of a drug to help protect the bones against pain and fracture. This infusion is to be given for as long as it is working (hopefully years)
- Weekly infusions of a drug to suppress the growth of the cancer. These infusions are to be given for as long as they are working (hopefully years).

Will her policy cover this treatment plan and are there any limits to the cover?

The whole of the treatment plan is eligible.

David's policy includes the cancer cover option. He has been with The Exeter for seven years when he is diagnosed with cancer. Following discussion with his specialist he decides to undergo a course of high dose chemotherapy, followed by a stem cell (sometimes called a 'bone marrow') transplant.

Will his policy cover this treatment plan and are there any limits to the cover?

As this is a new condition, the chemotherapy and stem cell transplant will be paid for provided that the procedure is not experimental, see 'Exclusions' on page 18.

When his treatment is finished, David's specialist tells him that his cancer is in remission. He would like him to have regular check-ups for the next five years to see whether the cancer has returned.

Will his policy cover this treatment plan and are there any limits to the cover?

The regular check-ups with David's specialist are covered in full providing he has pre-authorised each claim.

Jenny's policy does not include the cancer cover option. She has now been diagnosed with cancer.

What will her policy cover?

Any initial consultations and tests leading to Jenny's diagnosis would have been covered under the Out-Patient module (if selected) or the Essential module in the case of scans or in/day-patient procedures.

However, once cancer has been diagnosed, she will not be covered for any treatment, monitoring or any further diagnosis related to the cancer. Instead, she will need to be referred to the NHS for treatment.

Eric would like to be admitted to a hospice for care aimed solely at relieving symptoms.

Will his policy cover this and are there any limits to the cover?

We do not pay for admissions to a hospice. We will, however, make a £250 donation to the hospice Eric is admitted to.

Additional membership benefits

As a member of The Exeter, you have access to membership benefits that offer you additional care and support.

For more details, take a look at the 'Membership benefits' leaflet or visit www.the-exeter.com.

Excesses

Benefits paid under Health Choices for Me are subject to a compulsory excess of £100. We also offer a range of additional voluntary excesses – if you have chosen a voluntary excess this will be shown on your Policy Certificate.

The total excess (voluntary excess plus compulsory excess) then applies individually to each person to be covered by your policy in each policy year.

If there are multiple claims or conditions for one person within one policy year, then the total excess is only deducted once.

The table below shows how much you will have to pay towards eligible treatment each year based on the voluntary excess option you have selected.

Voluntary Excess	Your costs per policy year
Nil	You have to pay the first £100 of eligible treatment costs for each person covered by your policy each year
£100	You have to pay the first £200 of eligible treatment costs for each person covered by your policy each year
£250	You have to pay the first £350 of eligible treatment costs for each person covered by your policy each year

You should still submit a claim even if the eligible treatment costs are less than the excess because any excess payable on further claims in that policy year will be reduced by the amount of the earlier excess deduction.

If you incur costs that are not eligible under your policy those costs will not count towards your excess.

Remember, the total excess will apply to each person to be covered under your policy in each policy year. This means that if a course of treatment continues from one policy year to the next, the excess will apply again.

Please note that any entitlement to NHS Cash Benefit will also be subject to the total excess.

The following pages show examples of how excesses work in practice.

How does an excess work in practice?

Tom has Health Choices for Me, is the only person covered by his policy and has chosen a £250 voluntary excess. Tom's policy includes unlimited cover for out-patient treatment.

Tom's total excess is £350 (£100 compulsory + £250 voluntary).

Tom needs to make a claim for consultations and scans relating to a knee injury and the total invoice comes to £800. Provided all treatment costs are eligible under the policy Tom needs to pay £350 towards the claim and we will pay the remainder. However, if he needs to make any further eligible claims for the remainder of the policy year, no further excess payment will be due.

Janet has a Health Choices for Me policy which covers herself and her son Fred. They chose a £250 voluntary excess and the policy year starts on 1st January. Their policy includes unlimited out-patient and cancer cover but no cover for manipulative treatment.

The total excess on Janet's policy is £350 (£100 compulsory + £250 voluntary) per person per year.

Janet makes a claim in April for some consultations, scans and minor surgery relating to a shoulder problem. The overall eligible treatment costs came to just over £2,000, so she has to pay the first £350.

In July the same year, Fred is referred by his GP to a physiotherapist for a ligament problem. His treatment costs come to a total of £200, however as Fred is not covered for manipulative treatment, we will not pay anything towards this treatment and these costs will not count towards the £350 excess.

Later on that year Fred has a recurrence of the ligament problem and following a consultation needs to have some corrective surgery. The total eligible costs for treatment and consultation combined come to £2,000. This time, Fred's treatment is covered by the plan, so he will pay the first £350 and we pay the balance of £1,650.

Becky has Health Choices for Me, is the only person covered by her policy and has chosen a £100 voluntary excess. Her policy year runs from June 11th. Again, she has chosen to have unlimited out-patient cover under her policy.

Becky's total excess is £200 (£100 compulsory + £100 voluntary).

During late May, Becky injures herself playing badminton and is immediately referred by her GP to a specialist. She sees the specialist on 28th May and the bill for this is £230. Becky pays the excess of £200 and we pay the remaining £30.

Becky is then referred for a scan, which takes place on June 15th and the cost of which is £500. As a new policy year has started before this scan takes place, the excess applies again. Becky pays the £200 excess and we pay the remaining £300.

Mary has Health Choices for Me and has selected a voluntary excess of £100. Mary chose to cover herself for up to £300 per year manipulative treatment.

Mary's total excess is £200 (£100 compulsory + £100 voluntary).

In January, Mary injures her back and is referred to an osteopath. She has ten sessions of osteopathy at a cost of £40 per session, and sends the invoices to us.

Initially, we apply the benefit limits of her plan, £300 per year for manipulative treatment. This means that only £300 of the £400 treatment costs are eligible for benefit.

However, as Mary also has a total excess of £200 on her policy, we will then deduct this from the £300 allowable, so we will only be liable for £100 of the costs. Mary will therefore need to pay £300 of the costs herself. The following shows what would have been payable if only the compulsory excess had applied, together with the amount payable after also applying the voluntary excess.

	Compulsory £100 Excess	£200 Total Excess (Incl £100 voluntary)
Total of invoices	£400	£400
Benefit available	£300	£300
Excess deductible	£100	£200
Amount payable by us	£200	£100
Amount payable by Mary	£200	£300

Chronic conditions

A chronic condition is a disease, illness or injury that has one or more of the following characteristics:

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- It needs ongoing or long-term control or relief of symptoms
- It requires your rehabilitation or for you to be specially trained to cope with it
- It continues indefinitely
- It has no known cure
- It comes back or is likely to come back.

Please note that we do not consider cancer to be a chronic condition. Please refer to Cancer Cover on page 7.

Are you covered for chronic conditions?

If we believe that the condition for which you need treatment is chronic, we will pay for the initial investigations leading to a diagnosis and the treatment needed to stabilise the condition for a maximum of 3 months.

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

What if your condition gets worse?

If you have an acute episode of a chronic condition we will pay for the treatment of that episode.

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

If you need treatment to stabilise the condition we would therefore pay the costs.

We would usually request a medical report or ask for additional information.

The following pages show examples of how cover for chronic conditions works in practice.

Examples of chronic conditions

Angina & Heart disease

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

We don't class angina as a chronic condition, so as long as Alan has received authorisation from us and the investigations are covered under the benefit limits of the plan we will pay the costs 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 have a heart bypass operation.

We will pay the costs of the operation and any follow up treatment needed as long as benefits are available for these under the terms of the plan.

Asthma

Eve has been with The Exeter for five years when she develops breathing difficulties and her GP 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 that her breathing has been much better, so the specialist suggests she have check-ups every four months.

We will pay the cost of the initial consultation and tests, provided that Eve has received authorisation from us and benefits are available under the terms of the plan.

We will not, however, pay for the medication. Once the condition has stabilised, we will not pay for the check-ups.

Eighteen months later, Eve has a bad asthma attack.

Although we would describe Eve's asthma as a chronic condition, which we would not cover, we may consider this attack to be an acute episode. If so, and Eve needs treatment to stabilise her condition, we would consider paying the costs of further treatment providing benefits were available under the terms of the plan. We would usually ask for a medical report or additional information to help us with this decision.

Diabetes

Deidre has been with The Exeter for three years when she develops symptoms that indicate she may have diabetes. Her GP refers her to an endocrinology specialist who organises a series of investigations to confirm the diagnosis, and she then starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments made to her medication regime, the specialist confirms the condition is now well controlled and explains he would like to see her every four months to review the condition.

We class diabetes as a chronic condition. However, if Deidre has received authorisation from us and has the necessary cover options in the plan we will pay the costs for the initial consultation and any investigations, followed by the costs for any follow up consultations, but only until the condition has been stabilised.

We will not, however, pay for the medication.

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

Although we would describe diabetes as a chronic condition, which we would not cover, we may consider this an acute episode. If so, and Deidre needs treatment to stabilise her condition, we would consider paying the costs of further treatment providing they were covered under the benefit limits of the plan. We would usually ask for a medical report or additional information to help us with this decision.

Hip Pain

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

Once we have approved the claim, we will pay for the costs of the osteopathy treatment providing there is sufficient cover for manipulative treatment, until the condition has been stabilised. We will not pay for any treatment to manage the condition on a day to day basis.

Exclusions

We have tried to keep our exclusions as simple as possible - the table below details what isn't covered by Health Choices for Me.

Pre-existing conditions

Pre-existing conditions may be excluded from your cover. Please refer to the 'Underwriting' section for more information.

Treatment by your GP, optician or dentist

This includes consultations, tests, check-ups or prescriptions:

- provided by your GP, optician or dentist;
- provided in your GP surgery, or;
- provided by a consultant when ordinarily provided by your GP.

Sight, hearing or dental disorders

Consultations, tests or treatments for these disorders such as:

- Sight tests, treatment to correct long or short sightedness or astigmatism, optical aids such as spectacles
- Tests for hearing or deafness, provision of hearing aids, bone-anchored hearing aids or cochlear implants
- Dental care including check-ups, fillings, crowns, implants, bridges, dentures or orthodontics.

Emergency treatment

Emergency treatment is dealt with by the NHS and you are not covered until your consultant has decided you can transfer to private facilities and you have authorisation from us.

Out-patient drugs, dressings and medical aids

Drugs, dressings and medical aids resulting from out-patient treatment are not covered.

However, we do cover those prescribed immediately following an in-patient/ day-patient stay in hospital or out-patient surgery.

Please note that this exclusion does not apply to cancer drugs if your policy includes the cancer cover option. Please refer to Cancer Cover on page 7.

Conditions which are ongoing or long term

These are often known as chronic conditions and include diseases, illnesses or injuries such as diabetes, asthma or multiple sclerosis. These were dealt with in more detail on page 15.

However, please note that this exclusion doesn't apply to cancer treatment if your policy includes the cancer cover option. Please refer to Cancer Cover on page 7.

Renal dialysis

This includes regular or long-term renal dialysis and any treatment related to the dialysis in chronic or end-stage kidney failure.

Major organ transplants

These include investigations done before a major organ transplant operation or treatment needed as a result of a major general transplant operation.

However, we do cover corneal and skin grafts. If your policy includes the cancer cover option, we also cover transplants related to cancer, such as bone marrow and stem cell transplants, provided they are not experimental.
Please refer to Cancer Cover on page 7.

Mental & psychological treatment

This includes treatments for depression, stress, mental illness, psychiatric disorders and/or psychological disorders.

Treatment overseas

Treatment outside the UK is excluded.

Self-elected treatments

Self-elected treatment is not covered by Health Choices for Me.

Treatments in nursing homes

Treatments that take place in a nursing home or hospital which has become a place of permanent residence are excluded.

However, please note that this exclusion does not apply to cancer treatment if your policy includes the cancer cover option. Please refer to Cancer Cover on page 7.

Convalescence & rehabilitation

Convalescent and/or rehabilitative treatment are not covered by Health Choices for Me.

Preventative screening procedures, treatment & tests

These include:

- Screening procedures as a result of poor personal or family history
- Cervical smears, mammograms, preventative cancer screening, osteoporosis screenings etc
- Prophylactic surgical removal of healthy tissue intended to reduce future risk of disease (e.g. prophylactic mastectomy)
- Well person health checks and screenings
- Vaccinations, immunisations.

Learning and developmental disorders

We do not cover any treatment, investigations, assessment or grading related to learning disorders, educational problems, behavioural problems, physical development and psychological development.

Cosmetic and plastic surgery, bariatric and weight loss surgery

We do not cover cosmetic or plastic surgery or any treatment which relates to previous cosmetic or plastic surgery.

We do not cover bariatric surgery or any treatment as a consequence.

Neither do we cover treatment, including surgery:

- which is for or involves the removal of healthy tissue (i.e. tissue which is not diseased) or the removal of surplus fat or tissue; or
- where the intention of the treatment, whether directly or indirectly, is the reduction or removal of surplus fat or tissue including weight loss (for example, surgery related to obesity including morbid obesity).

These exclusions apply regardless of whether the treatment is needed for medical or psychological reasons.

However, if you need treatment to restore your appearance after illness or injury or as a result of surgery for cancer, then this will be covered if it forms part of the original course of treatment and providing the illness, injury or cancer surgery has been covered by your policy.

Pregnancy & fertility

We do not consider pregnancy or childbirth to be illnesses and therefore you are not covered for treatment or investigations in connection with:

- Pregnancy or childbirth
- Abortion
- Any form of assisted reproduction such as in vitro fertilisation
- Infertility.

However, illnesses unrelated to pregnancy, arising whilst pregnant or during childbirth, will be covered.

Complementary treatments

This includes treatments such as acupuncture, speech therapy, dietician, homeopathy and pain clinics.

However, we do cover physiotherapy, osteopathy, podiatry and chiropractic treatments if your policy includes the manipulative treatment cover option.

Professional sports injuries

Treatment required as a result of an injury sustained whilst training for or participating in professional sport. By this we mean engaging in sporting activities for which a salary, sponsorship, a benefit in kind, payment of expenses or financial support of any kind is received.

Experimental treatment

If any treatment or drug therapy is not clinically approved by NICE, it is not covered by Health Choices for Me. Please refer to page 6 for more details.

Underwriting

Your Policy Certificate will show you which of the following five types of underwriting applies to your policy - this section will explain how this impacts your cover.

Full medical underwriting

If the medical information that you provided with your application highlighted any pre-existing conditions that we felt would need treatment in the future, we may have applied medical exclusions to your policy. These exclusions will be shown on your Policy Certificate.

Standard moratorium

Benefits will not be available for treatment of any condition suffered if you had symptoms, medication, treatment or advice in connection with that condition in the five years before the start of your policy.

However, we will cover a pre-existing condition if you do not have symptoms, medication, treatment or advice in connection with that condition during a continuous two year period after the start of your policy.

Fixed moratorium

Benefits will not be available for treatment of any condition suffered if you had symptoms, medication, treatment or advice in connection with that condition in the five years before the start of your policy.

However, we will cover a pre-existing condition two years after the start of your policy, even if it has recurred during that two year period.

Continued Personal Medical Exclusions (CPME)

We will carry across the personal medical exclusions from your previous insurer and may have applied additional medical exclusions to your policy. These exclusions will be shown on your Policy Certificate.

Continued moratorium

Benefits will not be available for treatment of any condition suffered if you had symptoms, medication, treatment or advice in connection with that condition in the five years before the start of your previous policy with a different insurer.

However, we will cover a pre-existing condition if you do not have symptoms, medication, treatment or advice in connection with that condition during a continuous two year period after the start of your previous policy.

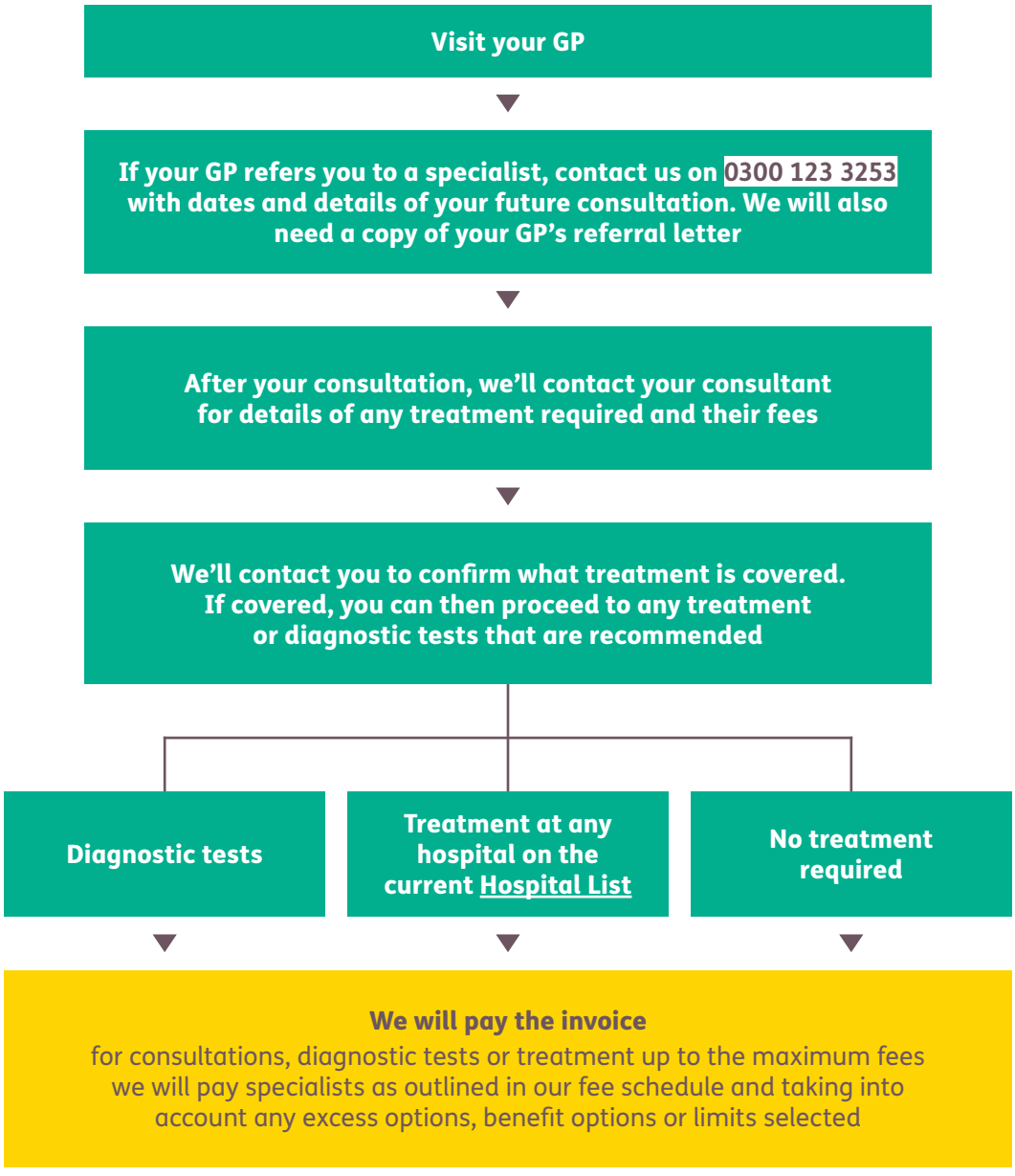
If you had your previous policy for more than two years without a recurrence, we will cover that condition immediately subject to the terms of your policy.

Making a claim

We want to ensure that any claim you make is as stress free as possible. We understand that when you or your family are ill, injured or require treatment, you want to know you're covered quickly and easily.

Our goal is to allow you to concentrate on what is most important - your health.

The claims process



Claims – important notes

- Claims must be authorised by us before you go ahead with any consultations, tests or treatment.

  This can be done by calling us on **0300 123 3253**. Treatment will only be eligible at a hospital on the current Hospital List. If you do not contact us for authorisation your claim may not be paid.

- Emergency treatment is dealt with by the NHS and you are not covered until your consultant has decided you can transfer to private facilities and you have authorisation from us.

  Please call us on **0300 123 3253** to authorise your claim.

- Claims will not be paid if your premiums are not up to date.

- If you have acted dishonestly or knowingly claimed for benefits to which you were not entitled, then we may cancel your policy. See 'When we may cancel your policy' on page 27.

- Additional information may be required from your GP at the time of claim.

- If you are claiming for NHS Cash Benefit, we will send you a form to complete. Claims for NHS Cash Benefit must be received within 3 months of the date of discharge.

- You must tell us when making a claim whether it is the result of an injury or illness caused by another party (for example, a road traffic accident or a trip in a shop) and you are making a claim for compensation against the other party. If so, you will need to keep us informed before accepting a final offer as we will expect our treatment costs to be included as part of the compensation claim.

- You must tell us if you make a claim under this plan and a claim can be paid under any other insurance policy. If so, we will only pay our proportionate share of the treatment costs.

Paying claims

We normally pay the hospital or specialist directly for your treatment.

Our payment will exclude any excess due, so you will be billed for this directly by the treatment provider.

If we have authorised treatment and you pay for it yourself, we will transfer the money due to you under your policy directly into the bank account you use for your premium payments. You must send receipted invoices to us within 3 months of the date of treatment.

Managing your membership

Having joined Health Choices for Me, this section explains how to continue your membership and the options available to change your cover.

Renewing Health Choices for Me

Health Choices for Me is an annual policy so you must renew it each year to continue your cover.

You can expect to be able to renew year after year as long as the plan is still being offered. In rare cases where we decide that a policy should not be renewed we will always give you due notice of our intention to refuse renewal.

We will write to you at least 21 days before your renewal date confirming the terms of your cover for the coming year, including any changes to the plan and the revised premium to be paid. The renewal also gives you the opportunity to make changes to your policy options for the forthcoming year.

Changes to your premiums over time

At renewal

We review premium rates annually to reflect the overall cost of providing cover, including claims and medical inflation. This can be influenced by factors such as the availability of new treatments and medical technologies.

In addition, Health Choices for Me is priced according to age, reflecting the fact that people are more likely to claim as they get older and their treatment is likely to cost more, so you will normally see an age-related premium increase each year.

At other times

Premiums for Health Choices for Me include Insurance Premium Tax (IPT).

If the Government changes the IPT rate, we will amend the premiums to incorporate the new rate and will give you reasonable notice prior to this change.

Changing your policy options

There are options available to make changes to your policy.

Option	Detail
Decreasing your cover by changing your module options	These changes can only be made at your annual renewal. Your premiums will be affected and we will confirm your new premium before making changes to your policy.
or	
Increasing your voluntary excess	
Increasing your cover by changing your module options	These changes can only be made at your annual renewal and if you are not currently claiming. We will check whether you are eligible to increase your cover under the terms of your underwriting option (see page 21) and we will also ask you to provide an update of your medical information to assess whether we can accept the change in cover. Your premiums will increase as a result and we will confirm your new premium before making changes to your policy.
or	
Reducing your voluntary excess	

Health discounts

With Health Choices for Me you are eligible for discounts if you have a healthy BMI and/or if you are a non-smoker. If you already have a discount this will be shown on your Policy Certificate.

If your entitlement has changed, then you need to let us know as we may not be able to pay a future claim if you benefit from these discounts when they are not due to you.

The eligibility for both discounts is as follows:

Body Mass Index (BMI)

BMI is calculated from a person's height and weight.

To receive a 10% discount your BMI must be over 18 and under 25 - there are many BMI calculators available online for you to check your entitlement.

Non-smoking

To receive a 10% discount you must be a non-smoker. We define a non-smoker as someone who has not smoked or used nicotine replacement products in the last 12 months.

Changing your address

Health Choices for Me is a regionally priced product, so if you move to a new address, your premium may change part-way through a policy year to reflect your new postcode. You must be a resident of the UK to have a Health Choices for Me policy.

Adding or removing family members

Your premium may change if you add a dependent to your policy or remove one from it during a policy year. If your child is between 3 months and 1 year old, you can add them to your policy on your next payment due date. Other children under 21, or under 25 if in full time education, can be added at your next renewal.

Children aged 5 years and under are covered for free. Added children will be underwritten via an application form and will have the same excess as the policyholder.

To add a dependant, contact us on **0300 123 3201** and we'll send you a form to complete.

Paying your premiums

You must continue to pay your premiums regularly by monthly Direct Debit. If you fall behind on your premium payments you will not be able to make a claim.

If you miss one month's premiums you will need to pay any premiums you missed.

If you miss two months' premiums we'll ask you to provide an update of your medical information to assess whether your cover can start again. You'll also need to pay any premiums you missed.

If you miss three months' premiums or more we will cancel your policy with effect from the first unpaid premium. If you want to re-join you will need to complete a new application.

Cancelling your policy

You can cancel your policy at any time.

If you cancel within 30 days of when the policy starts, we will refund any premiums you have paid, as long as you have not made a claim. If you cancel the policy after the 30 day period, there is no cash in value and any premiums you have paid will not be refunded.

If you are receiving treatment which is covered by your policy at the time your cover ends, you will need to make arrangements with your specialist to transfer to NHS care or for you to continue funding private treatment yourself.

When we may cancel your policy

In the following circumstances, we may cancel your policy.

- If you have acted dishonestly or knowingly claimed for benefits to which you were not entitled. In this event we will recover any benefits paid to you and will not refund any premiums
- If you did not take reasonable care to answer the questions to the best of your knowledge when you applied for this policy.

If you want to cancel your Health Choices for Me policy:

please contact us on **0300 123 3201**

send an email to member@the-exeter.com

or write to us using the address over the page.

Further information

Contacting us

Telephone
0300 123 3201 (General enquiries)
0300 123 3253 (Claims)

Email
member@the-exeter.com

In writing
The Exeter
Lakeside House
Emperor Way
Exeter EX1 3FD

Website
www.the-exeter.com

Feedback and complaints

We aim to provide our members with quality products complemented by a simple and efficient service.

When we exceed your expectations it's nice to receive that feedback, so please let us know.

Whilst we hope you won't ever have cause to complain, if for any reason you are unhappy with our products or service please contact us:

By email: member@the-exeter.com

By telephone: 0300 123 3201

By post: The Exeter, Lakeside House, Emperor Way, Exeter, EX1 3FD

We will investigate your complaint and respond to you, and if you remain unhappy we will escalate your concerns to an impartial complaints handler.

If we remain unable to resolve your complaint to your satisfaction, or we do not respond within 8 weeks, you have the option of asking the independent Financial Ombudsman Service to investigate on your behalf. You can visit their website at www.financial-ombudsman.org.uk or you can contact them on 0800 023 4567 or 0300 123 9123.

Language and Law

All documents relating to Health Choices for Me, including any communications with you, will be in English.

The laws of England and Wales apply to Health Choices for Me.

Financial Services Compensation Scheme (FSCS)

The Exeter is covered by the FSCS, which was established under the Financial Services and Markets Act 2000. This means that you may be entitled to compensation if we become insolvent and are unable to meet our obligations.

Further details are available from the FSCS at www.fscs.org.uk or you can telephone them on **0800 678 1100** or **020 7741 4100**.

What we require from you

You must answer any questions you are asked as fully and as accurately as you can, to the best of your knowledge and belief.

If you do not, we may refuse to pay your claim and could cancel your policy.

How we handle information about you

Due to the nature of what we do, we hold personal information about you.

This means that we can make sure we provide the best quality cover that you expect. You have our assurance that this information will always be treated with confidence.

We will use the information to contact you about your policy at renewal, to update you, ask for feedback and when you are making a claim.

However, there are other reasons why we would use this information, such as:

- Cooperation with fraud prevention agencies
- Transmission to those involved in your treatment or care and for the purposes of providing any add-on services related to your policy
- Retaining cancelled policies and associated details to assist us in determining future applications for insurance that you may wish to make
- Passing information to carefully selected parties (including the intermediary who arranged your cover, if any) as part of our administering your plan
- Passing information to carefully selected parties for research, advertising or marketing purposes (for example, to tell you about new products)
- Passing information to your solicitors or a third party where somebody else caused your claim
- Passing information to other insurers to recover our proportionate share of treatment costs following a claim.

Further information about why we hold this information can be found in the Register of Data Controllers. You can view and obtain a copy from the Office of the Information Commissioner at www.ico.gov.uk.

Contact us

The Exeter, Lakeside House, Emperor Way, Exeter, EX1 3FD

Members
General enquiries: 0300 123 3201
Claims: 0300 123 3253

member@the-exeter.com

Financial Advisers
All enquiries: 0300 123 3203

adviser@the-exeter.com

www.the-exeter.com

Calls may be recorded and monitored.

2018/2717