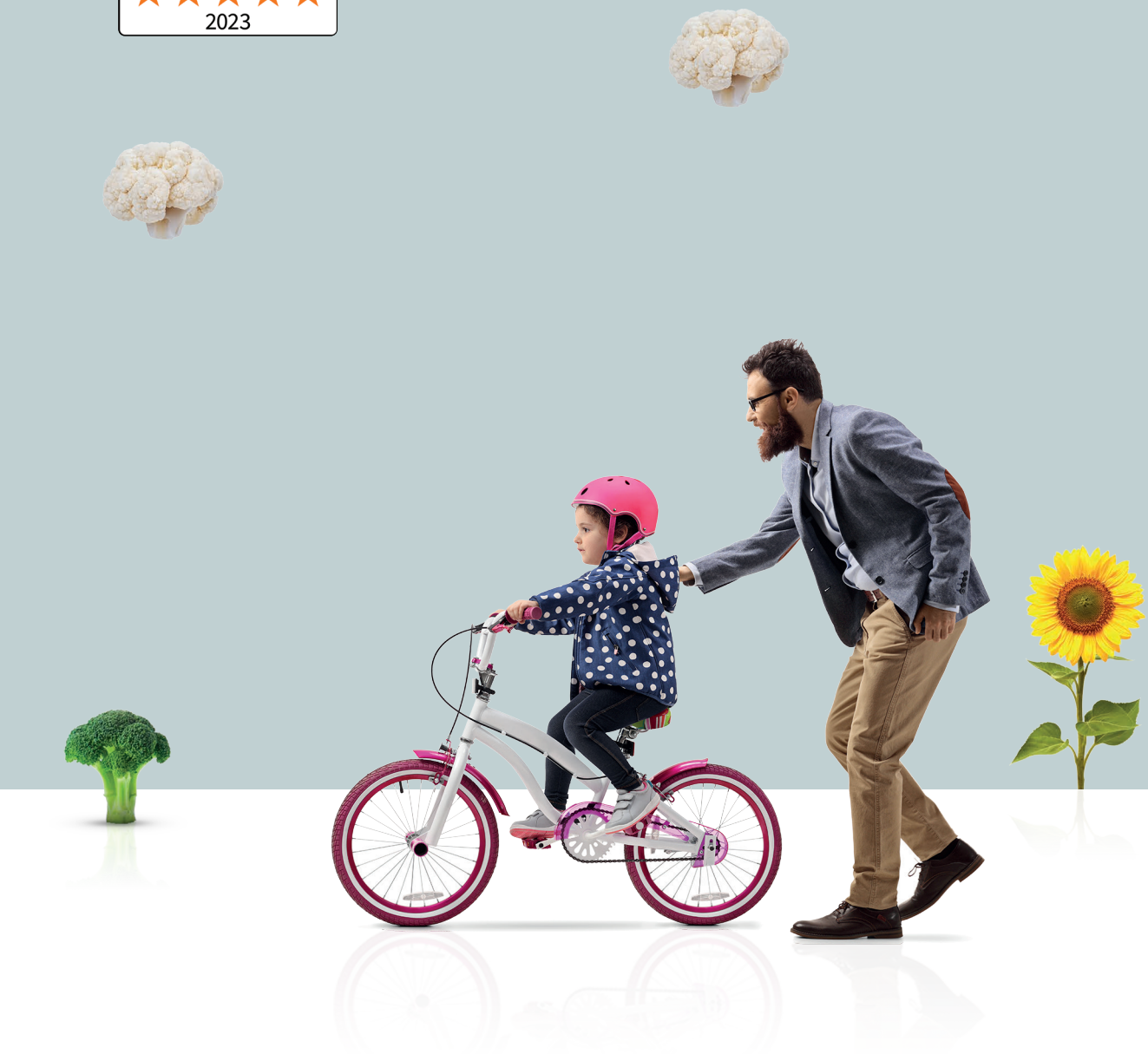
HEALTH+

Policy Document.

defaqto
EXPERT RATED
★★★★★
2023



The Exeter

You matter more.

Contents

Welcome to **Health+** by The Exeter

Health+ is a private health insurance policy designed to help people, just like you, get the fastest possible diagnosis and the best possible private treatment. This document contains the terms and conditions of your policy – please read it with your Policy Certificate for full details of cover.

Members of **Health+** will also become members of The Exeter.

Members over the age of 18 also have the right to have their voice heard by voting in our Annual General Meeting (AGM), which gives our members a say in how we're run.

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 indicate a signpost to another part of the document or a separate brochure.

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 a member to the state of health they were in immediately before suffering the disease, illness or injury or which leads to their full recovery.

Benefit
The amount we pay following a successful claim.

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

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

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 a member's rehabilitation or for a member 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.

Community rated
A premium structure where future premiums reflect the claims made by a wider pool of customers, not individual claims made only by members under this policy.

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.

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

Excess
The amount which will be deducted from the eligible treatment costs for each member, each policy year.

Fee schedule
This sets out the maximum fees we will pay specialists for the treatment they provide. If your policy includes guided specialist, we'll pay the full cost of the fees as we give you the choice of specialists to use. The most up-to-date fee schedule is available on our website.

GP
A general practitioner on the General Medical Council (GMC) GP register from the member's registered practice.

Guided specialist
If your policy includes guided specialist, all of your treatment will be with a specialist we have helped you find. Members with guided specialist need an open referral from their GP if they are referred for treatment. If you selected a hospital list then your policy will not include guided specialist.

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
If your policy includes a hospital list, you are only eligible for treatment at hospitals on your chosen list, which will be shown on your Policy Certificate. Hospital lists often change, so always check with us before arranging treatment. If you selected guided specialist then your policy will not include a hospital list.

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

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.

Member
Anyone covered by the policy and named on the Policy Certificate.

No Claims Discount
A premium structure where future premiums reflect the claims made by individual members. The No Claims Discount (NCD) scale has 15 levels and the maximum discount you can receive is 75%. If your policy includes a NCD your discount will be shown on your Policy Certificate. If your policy does not include a NCD you will be on a Community Rated premium structure.

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.

Policy
Our contract of insurance with you.

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

Policyholder
Anyone named as a policyholder on the Policy Certificate and who can make changes to this policy.

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

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

- members have received medication, advice or treatment; or
- members 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 as detailed on the Policy Certificate.

Specialist
A healthcare professional to whom a member is referred by their General Practitioner (primary care physician) for secondary care. This person must be on the GMC Specialist Register or equivalent overseas and must be recognised by us.

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

United Kingdom (UK)
England, Scotland, Wales and Northern Ireland.

We/Our/Us
The Exeter, a trading name of Exeter Friendly Society Limited.

You/Your
Anyone named as a policyholder on the Policy Certificate.

Cover and benefits

With exceptional core cover and simple benefit add-ons, **Health+** gives you all the control and flexibility you need to build the right policy at the right price. This section details what is and isn't covered by your **Health+** policy with The Exeter.

Your policy is made up of the following documents:

Your application for cover
This includes your initial application and any further applications you make where your cover is varied. It also includes any declarations made when you applied for cover.

Your Policy Certificate
This sets out the current details of your cover. Your Policy Certificate shows any exclusions we may apply to your cover.

This Policy Document
This contains all the terms and conditions of your cover.

Core cover

The table below shows the core cover that your **Health+** policy provides – you should read this alongside the other sections of this document, particularly Definitions and Making a claim, together with the remainder of this section.

0300 123 3253

All you need to remember before going ahead with any tests or treatment is to contact us and we'll guide you through the claims process.

Approved treatment requires referral from a GP.

Treatment will only be covered based on your chosen treatment option:

- If you selected **guided specialist**, we will only pay for treatment with specialists that we have helped you to find
- If you selected a hospital list, we will only pay for treatment at a hospital on your chosen list.

What can you claim for?	What does this include?	Benefit available
In-patient and day-patient treatment	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).	Unlimited
Cancer	Treatment and specialist consultation for diagnosed cancer. For more details go to the Cancer cover section on page 11.	Unlimited
CT, MRI and PET scans	CT, MRI and PET scans. Includes professional fees where appropriate.	Unlimited
Out-patient surgery	Surgical procedures performed by a specialist.	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	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 a member had free in-patient treatment, including cancer treatment, under the NHS that would be covered under your policy.	£150 per night for up to 30 nights
Hospice donation	A donation to your hospice if you are admitted for care.	£250

Benefit add-ons

The table below shows the options to personalise your cover. The options you currently have will be shown on your Policy Certificate.

Benefit add-on	What does this include?	Your benefit options
Out-patient	Specialist consultation fees. Diagnostic tests such as X-rays, ECGs and pathology tests. Please note that CT, MRI and PET scans are included as standard under core cover.	Unlimited Up to £1,000 per policy year Up to £500 per policy year No cover
Unlimited out-patient diagnostics	With this option, out-patient diagnostic tests are covered in full, and only specialist consultation fees are deducted from your chosen out-patient benefit limit.	Unlimited No cover
Therapies	GP or specialist referred treatment by a: ■ Physiotherapist ■ Chiropractor ■ Osteopath ■ Acupuncturist ■ Podiatrist ■ Speech therapist ■ Pain clinic ■ Dietician (maximum of two consultations for each member per policy year).	Unlimited Up to £1,000 per policy year Up to £500 per policy year No cover
Mental health	**In-patient and day-patient** Specialist fees and diagnostic tests as an in-patient or day-patient. Treatment and hospital charges as an in-patient or day-patient limited to 28 days for each member each policy year. **Out-patient** Specialist consultation fees for psychiatric treatment. This includes psychiatric treatment by psychiatrists, psychologists and cognitive behavioural therapists.	Unlimited (28 days in/day-patient cover) No cover

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+**.

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 policy.

Will treatment charges be paid in full?

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

Firstly, what is covered by your **Health+** policy and to what level is dependent on the choices you made at application. For example, if your policy includes £500 of out-patient cover as a benefit add-on and your claim totals £600 for out-patient consultations, you will have to pay the difference of £100.

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

- If you selected **guided specialist**:

We will help you find an approved specialist. This means we'll pay all eligible specialist fees in full.

- If you selected a hospital list:

We will pay the treatment charges up to the amount published in our fee schedule, which sets out the maximum fees we will pay specialists for the treatment they provide to members. 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 treatment. In this case you will have to pay the remainder of the fee, this is commonly known as a shortfall.

Finally, the benefit we pay will be subject to any excess that applies.

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 one of the most important and reassuring aspects of having private health insurance. **Health+** offers cover for all stages of cancer once diagnosed.

	What benefit is available?
Place of treatment	**Full cover** for treatment and chemotherapy administered at home if necessary.
Diagnostic	**Full cover** for specialist consultations, tests and scans after the cancer has been diagnosed. Consultations and tests to establish a diagnosis would be covered under the out-patient or unlimited out-patient diagnostics benefit add-on (if selected) or core 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.
Drug therapy	**Full cover** for all types of drug therapy for cancer, including chemotherapy and 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 a member is admitted for care. **Full cover** for care of terminal cancer while awaiting admission to a hospice.
Monitoring	**Full cover** for follow up reviews related to the continuing care of 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 cancer cover 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.
NHS cash benefit	**£150 per night for up to 30 nights** if a member has free in-patient treatment for cancer under the NHS that would otherwise have been covered under your policy.

Please note that cancer cover is also subject to the general terms and conditions of this policy, in particular the section Will treatment charges be paid in full? Remember that members must contact us before going ahead with any consultations, tests or treatment.

Examples of how cancer cover works in practice

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

Example 1

David 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?

The chemotherapy and stem cell transplant will be covered in full provided that the procedure is not experimental, see Exclusions on page 19.

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?

Yes. This policy covers monitoring, so the regular check-ups with David's specialist are covered in full providing he has pre-authorised each claim.

Example 2

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?

As hospices don't charge for their care, we will make a £250 donation to the hospice Eric is admitted to.

Example 3

Beverley 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?

Yes. Her policy will cover the consultations, operation and breast reconstruction in full. Crucially, it will also cover 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?

Yes. Her policy will cover the blood transfusion and course of injections in full.

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?

Yes. Her policy will cover the admission to hospital and 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?

Yes, her policy will cover the whole treatment plan in full.

No Claims Discount (NCD)

If your policy includes a No Claims Discount (NCD) this will be shown on your Policy Certificate. Our NCD scale has fifteen levels. The NCD cannot fall below level 0 or exceed level 15, as shown below.

NCD level	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Premium Discount	0%	9%	18%	25%	32%	39%	45%	50%	54%	59%	63%	66%	70%	72%	74%	75%

How claiming affects the NCD

Each member will have their own NCD, so a claim made by one member on the policy will not affect the NCD of others. The NCD is reviewed each year by combining the amounts we have paid for each member in the review period. See When we review the NCD for details.
The NCD will not go down by more than three levels at renewal and is tiered relative to the size of the claims. The table below shows how the claims each member makes will affect their NCD level.

Total we have paid towards claims in the NCD review period	Change in discount applied at renewal date
£0.00	Move up the scale by one level
£0.01 – £300	Remain at your current level
£300.01 – £1,000	Move down the scale by one level
£1,000.01 – £2,000	Move down the scale by two levels
£2,000.01 and above	Move down the scale by three levels

When working out the discount, we use the date we paid the claim rather than the date the treatment took place. It's important that members do not delay seeking treatment because of the impact it will have on the NCD. If you have any concerns, you can contact us on **0300 123 3201**.

Claims that don't affect the NCD

The following claims will not affect the assessment of the NCD:

- NHS cash benefit
- Hospice donations
- Any claim that is lower than your excess amount.

When we review the NCD

We will review all claims to work out the discount for each member before your renewal date, as shown by the table below. This is known as the NCD review period. If a member makes a claim after their NCD review, it will not affect their discount until the following renewal.

Policy year	Months included in the NCD review
Year 1	Months 1 – 10
Year 2 onwards	Months 11 and 12 of the previous policy year plus months 1 – 10 of current policy year

Protected NCD

If your policy includes protected NCD this will be shown on your Policy Certificate.

NCD protection takes effect when a member makes a claim that would normally cause them to drop down the NCD scale, regardless of how many levels. Instead they will remain at their current NCD level.

Once the NCD protection has taken effect it will be removed for that member at your policy renewal date. However, it will still apply to any other members until their NCD protection has taken effect and it can also be reinstated in the future.

For information about adding or removing protected NCD, see the Managing your policy section.

Related claims

We understand that sometimes a claim will be ongoing across two NCD review periods. If this occurs, these claims will be classed as related claims, which can help protect a member's position on the NCD scale.

Related claims are claims that:

- are paid in different NCD review periods ; and
- are paid within 180 days of paying the first invoice for the claim.

The NCD will not go down by more than three levels on related claims

Therefore, if we pay a claim that causes a member to move three levels down the scale during one review period, and we make a further payment for a related claim in the following review period, that member will not move further down the scale for that claim.

Similarly, if we pay a claim that causes a member to move two levels down the scale during one review period, and we make a further payment for a related claim in the following review period, that member will only move a maximum of one level down the scale for that claim.

See Jane's example that follows for more details.

How does a No Claims Discount work in practice?

Example 1

Simon has a Health+ policy with a No Claims Discount which covers him and his daughter. He is in his first policy year which runs from January 1st.

In August, his daughter is admitted to hospital. We approve the claim and pay a total of £1,500 in September. Simon makes no claims in the first year. In Simon's annual NCD review we include claims that we paid between January 1st and October 31st (months 1 – 10). Simon's daughter therefore moves down the scale by two levels based on the total we paid for her claim, while Simon moves up the scale by one level as he made no claims.

Example 2

Jane has been a Health+ member for three years. Her policy year runs from March 1st and includes a No Claims Discount.

In September, Jane develops knee pain and is referred by her GP to a specialist. After we pre-authorise her claim, Jane has a number of investigations and is diagnosed with arthritis of the knee. She requires a knee replacement and has the operation in November. Jane's full treatment plan costs £17,000. We paid for her specialist consultations and scans in October and her operation in December.

In Jane's NCD review we include claims we paid between January 1st and December 31st (months 11 and 12 of the previous policy year plus months 1 – 10 of the current policy year).

Jane therefore moves three levels down the scale at renewal. In January, Jane begins her post-operative physiotherapy. We pay a total of £400 in March, which falls into a new NCD review period.

As Jane's claim was for the same medical condition she claimed for in the previous review period, and we paid it within 180 days of the first payment, this is a related claim. As Jane previously moved down the scale by three levels, she will therefore remain at her current level following the next NCD review, providing she makes no further claims.

Excess

If your policy includes an excess this will be shown on your Policy Certificate.

Excesses apply individually to each member in each policy year. If there are multiple claims or conditions for one member within one policy year, then the excess is only deducted once.

If an excess is paid towards eligible treatment costs that are subject to a benefit limit, we will not reduce the benefit available by the excess amount. See Mary's example on page 18 for more details.

Excess options on **Health+** are shown in the table overleaf.

Excess	Your costs per policy year
Nil	You don't have to pay anything towards eligible treatment costs
£100	You have to pay the first £100 of eligible treatment costs for each member each policy year
£250	You have to pay the first £250 of eligible treatment costs for each member each policy year
£500	You have to pay the first £500 of eligible treatment costs for each member each policy year
£1,000	You have to pay the first £1,000 of eligible treatment costs for each member each policy year
£3,000	You have to pay the first £3,000 of eligible treatment costs for each member each policy year
£5,000	You have to pay the first £5,000 of eligible treatment costs for each member each policy year

Members 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 a member incurs costs that are not eligible under your policy those costs will not count towards their excess.

Remember, the total excess will apply to each member 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, however we do not deduct an excess from a hospice donation.

How does an excess work in practice?

Example 1

Tom has a Health+ policy, is the only person covered by his policy and has chosen a £250 excess. Tom's policy includes the unlimited out-patient benefit add-on.

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 £250 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.

Example 2

Janet has a Health+ policy which covers her and her husband Fred. They chose a £250 excess and the policy year starts on 1st January. Their policy includes the unlimited out-patient benefit add-on but no cover for therapies.

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 £250. 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 therapies, we will not pay anything towards this treatment and these costs will not count towards the £250 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 policy, so he will pay the first £250 and we pay the balance of £1,750.

Example 3

Becky has Health+, is the only person covered by her policy and has chosen a £100 excess. Her policy year runs from June 11th. She has chosen the unlimited out-patient benefit add-on.

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 invoice for this is £180. Becky pays the excess of £100 and we pay the remaining £80.

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 £100 excess and we pay the remaining £400.

Example 4

Mary has Health+ with an excess of £250. Mary chose £500 of therapies cover as a benefit add-on.

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.

Mary pays the excess of £250 and we pay the remaining £150.

As we do not reduce benefit available by the excess amount, Mary will still have £350 of therapies cover remaining for the policy year (as we have paid £150 towards treatment so far).

Exclusions

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

	What isn't covered
Alcohol, drug or substance abuse	Treatment that arises from or is in any way connected with excess alcohol intake or drug or substance abuse.
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 are dealt with in more detail on page 22. **However, please note that this exclusion doesn't apply to cancer treatment. Please refer to Cancer cover on page 11.**
Convalescence and rehabilitation	Convalescent and/or rehabilitative treatment.
Cosmetic and plastic surgery, bariatric and weight loss surgery	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 a member needs treatment to restore their appearance after illness or injury or as a result of surgery for cancer, then this will be covered if the original surgery was covered by your policy and providing benefit is available.**
Deliberate self-inflicted injury or suicide attempt	Treatment required as a result of a deliberately self-inflicted injury or a suicide attempt.

	What isn't covered
Emergency treatment	Emergency treatment in an Accident & Emergency unit or other urgent care centre.
Experimental treatment	Treatment or drug therapy not clinically approved by NICE. Please refer to page 10 for more details.
Learning and developmental disorders	Treatment, investigations, assessment or grading related to learning disorders, educational problems, behavioural problems, physical development and psychological development such as Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum disorders.
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. 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 11.**
Mental and psychological treatment	This includes treatments for depression, stress, mental illness, psychiatric disorders and/or psychological disorders. **However, please note that this exclusion does not apply if your policy includes the mental health benefit add-on.**
Out-patient drugs, dressings and medical aids	Drugs, dressings and medical aids resulting from out-patient treatment. **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. Please refer to Cancer cover on page 11.**
Pre-existing conditions	Pre-existing conditions may be excluded from your policy. Please refer to the Underwriting section for more information.
Pregnancy and fertility	We do not consider pregnancy or childbirth to be illnesses, so this policy does not cover 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.**

	What isn't covered
Preventative screening procedures, treatment and 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.
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.
Renal dialysis	This includes regular or long-term renal dialysis and any treatment related to the dialysis in chronic or end-stage kidney failure.
Self-elected treatments	Treatment a member chooses to have without referral from a GP or without pre-authorisation from us.
Sex change / gender re-assignment	Sex change / gender re-assignment treatment or anything connected with it.
Sight, hearing or dental treatment	Consultations, tests or treatments 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.
Treatment by a GP, optician or dentist	This includes consultations, tests, check-ups or prescriptions: ■ provided by a GP, optician or dentist; ■ provided in a GP surgery, or; ■ provided by a specialist when ordinarily provided by a GP.
Treatments in nursing homes	Treatments that take place in a nursing home or hospital which has become a place of permanent residence. **However, please note that this exclusion does not apply to cancer treatment. Please refer to Cancer cover on page 11.**
Treatment overseas	Treatment outside the UK.

Chronic conditions

This policy covers treatment of acute conditions. It does not cover 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 rehabilitation or for a member 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 11.

Cover for chronic conditions

If we believe that the condition for which a member needs 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 three months.

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

What if the condition gets worse?
If a member has 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 leading to hospitalisation would be classed as an acute episode.

If a member needs treatment to stabilise the condition, we would therefore pay the costs for a maximum of three months.

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

How does cover for chronic conditions work in practice?

Angina and 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 has benefit available we will pay the costs for these investigations.

We will not, however, pay for the medication as drugs and dressings resulting from out-patient treatment are not covered.

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 Alan's policy has benefit available.

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 her policy.

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 describe Eve's asthma as a chronic condition, which we would not cover, if she is admitted to hospital we will consider this attack to be an acute episode. If Eve needs treatment to stabilise her condition, we will pay the costs of further treatment providing she has benefit available for a maximum of three months. 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 benefit available 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 for a maximum of three months.

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 describe diabetes as a chronic condition, which we would not cover, we consider this an acute episode and will therefore pay the costs of this episode. 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 benefit is available. If Bob's hip pain is diagnosed as a chronic condition, we will pay for the costs of treatment until the condition has been stabilised for a maximum of three months.

Underwriting

Your Policy Certificate will show which underwriting terms apply to your policy – this section will explain how this impacts your cover.

Full Medical Underwriting

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

Standard Moratorium

Benefits will not be available for treatment of any condition suffered if a member 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 a member does not have symptoms, medication, treatment or advice in connection with that condition during a continuous two year period after the start of your policy.

Continued Personal Medical Exclusions

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

Continued Moratorium

Benefits will not be available for treatment of any condition suffered if a member 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 a member does 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. We may have applied additional medical exclusions which will be shown on your Policy Certificate.

If any member makes a claim on a policy with moratorium underwriting terms, we may request up to five years of medical records in English to determine whether the condition was pre-existing or not, or whether there have been two clear years free of the condition. If this cannot be provided, we may not be able to pay a claim.

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

Check your treatment option on your Policy Certificate

↓

Visit your GP

↓

If you have **guided specialist**:

And your GP refers you for treatment, or to see a specialist, it is important that you ask them for an 'open referral'. This means that the GP doesn't name a particular specialist, but the type of specialist you need to see. Then contact us on **0300 123 3253** with details of the open referral and we will give you a choice of up to three specialists. We will need to see a copy of the open referral letter

If you have a hospital list:

And your GP refers you for treatment or to see a specialist, you should then contact us on **0300 123 3253** with details of the referral. We will need to see a copy of the GP's referral letter

↓

After the consultation, you should let us know the outcome and if necessary we will contact your specialist to request details of any treatment required

↓

We will confirm what is covered and you can then proceed with any diagnostic tests or treatment that is recommended

↓

Diagnostic tests | Treatment | No treatment required

↓

We will pay the invoice
for consultations, diagnostic tests or treatment, taking into account any options, such as your excess, any benefit limits and specialist fees.

Claims – important notes

- Members can claim for themselves from the age of 16
- Claims must be authorised by us before any consultations, tests or treatment

  This can be done by calling us on **0300 123 3253**. If you do not contact us for authorisation the claim may not be paid
- Treatment will only be covered at an eligible hospital based on your chosen treatment option:
  - If you selected **guided specialist**, we will only pay for treatment with specialists that we have helped you to find
  - If you selected a hospital list, we will only pay for treatment at a hospital on your chosen list
- Additional information may be required from a member's GP at the time of claim
- If a member receives a referral from a GP not at their registered practice, we may need to contact their registered practice for information about their medical history
- Emergency treatment in an Accident & Emergency unit or other urgent care centre is not covered
- Claims will not be paid if your premiums are not up to date
- If a member has acted dishonestly or knowingly claimed for benefits to which they were not entitled, then we may cancel your policy.
  See When we may cancel your policy on page 31
- If a member is claiming for NHS cash benefit, they must contact us within three months of the date of discharge
- Members 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 they are making a claim for compensation against the other party. If so, they will need to keep us informed before accepting the final offer as we will expect our treatment costs to be included as part of the compensation claim
- Members must tell us if they make a claim under this policy which 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 treatment.

Our payment will exclude any excess or shortfall, so you will be invoiced for this directly by the treatment provider, if this applies.

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 three months of the date of treatment.

Managing your policy

Having joined **Health+**, this section explains how to continue your policy and the options available to change your cover.

Renewing Health+

Health+ 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 **Health+** 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.

We will write to you before the renewal date confirming the terms of your cover for the coming year, including any changes to **Health+** 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. This includes medical inflation, which can be influenced by factors such as the availability of new treatments and medical technologies.

If you have a No Claims Discount, your individual claims will impact your future premiums, as explained in the No Claims Discount section. If you are on a Community Rated premium structure, your future premiums will reflect the claims made by a wider pool of customers.

In addition, **Health+** is priced according to age, reflecting the fact that people are more likely to claim as they get older, so you will normally see an age-related premium increase each year.

At other times

Premiums for **Health+** 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

There are options available to make changes to your policy, as shown below.

Options to reduce your premiums	
Decreasing your cover by changing your benefit add-ons	These changes can only be made at your renewal. Your premiums will be reduced and we will confirm your new premium before making changes to your policy.
Increasing your excess	
Downgrade your treatment option to a reduced hospital list or to guided specialist.	If you are currently claiming or receiving ongoing treatment, it may not be appropriate to change your treatment option, if for example, you wish to attend a specific hospital facility or be seen by the same consultant.
Removing NCD protection	

Options to increase your cover	
Increasing your cover by changing your benefit add-ons	These changes can only be made at your renewal and if no members are claiming at the time. We will ask members to provide an update of their 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.
Reducing your excess	
Upgrade your treatment option from guided specialist to a hospital list, or by upgrading your hospital list.	If you have not previously protected your NCD, you can add this option if you have been claim free in the last NCD review period. However, if you previously protected your NCD but have lost this option following a claim, you can only add it again once you have been claim free in an NCD review period.
Adding NCD protection	

Changing your address

Health+ 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 England, Scotland, Wales or Northern Ireland to have a **Health+** policy.

Adding or removing family members

Your premium will change if you add family members to your policy or remove them from it during a policy year.

You can add children under the age of 1 to your policy on your next payment due date. Adults or children under 21, or 25 if in full time education, can be added at your next renewal.

Added spouse, partners or children will be underwritten via an application form and will have the same excess as you.

To add a family member, 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 or annually by either Direct Debit or debit or credit card.

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 no members have made a claim.

If you cancel the policy after the 30 day period, any refund will depend on how you pay for your premiums:

If you pay monthly, any premiums you have paid will not be refunded.

If you pay annually, we will refund any overpaid premiums on a pro rata basis, calculated by the number of complete months remaining in the policy year.

We will refund any overpaid premiums in the event of the death of a member, providing we are notified within 6 months. This will be calculated by the number of complete months that have been overpaid, following the date of the member's death.

We will not pay for any treatment once your cover has ended. If you are receiving treatment at the time your cover ends, you will need to make arrangements with your specialist to transfer to NHS care or continue funding private treatment yourself.

When we may cancel your policy

If any member has acted dishonestly or knowingly claimed for benefits to which they were not entitled. In this event we will recover any benefits paid 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.

Our staff are expected to treat individuals with courtesy, respect and fairness. Similarly, we expect our staff to be treated in the same way. We have a duty to protect the welfare and safety of staff. Where individuals behave unacceptably or unreasonably, we reserve the right to cancel your policy.

Further information

How we handle information about our members

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

This enables us to provide the quality cover you expect. This information will always be treated in confidence.

We will use the information to contact you about your policy each year, to update you, ask for feedback and when a member makes a claim.

To find out more, go to our website **www.the-exeter.com/privacy-policy** or contact us and we will send you a copy.

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**

Language and law

All documents relating to **Health+**, including any communications with our members, will be in English.

This document is available in other formats. If you would like a Braille or large print version of this document, please contact us.

The laws of England and Wales apply to **Health+**.

Information about the quality and cost of private treatment

You can find independent information about the quality and cost of private treatment available from doctors and hospitals from the Private Healthcare Information Network: **www.phin.org.uk**

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.

Contact us

Call us:

General enquiries **0300 123 3201**

Claims **0300 123 3253**

Write to us:

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

Email us:

member@the-exeter.com

You can find out more about us and all our products at:

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 using the details above.

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**.

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**.

You matter more.

The friendly specialists in income protection, life cover, health insurance and cash plans.

Contact us

Members:
Enquiries: 0300 123 3201
Claims: 0300 123 3253
member@the-exeter.com

Financial Advisers:
Enquiries: 0300 123 3203
adviser@the-exeter.com

Opening times:
Monday to Friday 8am – 6pm

Calls may be recorded and monitored.

Postal address:
The Exeter, Lakeside House, Emperor Way, Exeter EX1 3FD

Website:
the-exeter.com

The Exeter

You matter more.