keyfacts®

National friendly

Optimum
Out-patient Plan
Policy Summary

Introduction

This is an important document which you should read before deciding whether to apply for the Out-patient Plan. It provides a summary of the cover provided by the policy and how we deal with claims, to help you decide if the Out-patient Plan is right for you.

The Out-patient Plan is an insurance policy which provides access to faster diagnosis of medical conditions via private healthcare services.

We do not offer advice or recommendations. To check whether this product will meet your demands and needs you should read this Policy Summary carefully.

Full details of the policy benefits and exclusions are provided in the Terms and Conditions and Policy Schedule which we provide to you once you have taken out the policy. A copy of the Terms and Conditions can be obtained on request before you take out the policy.

We recommend you review and update your cover periodically to ensure it remains adequate for your needs.

National Friendly is referred to as 'we' or 'us' in this document.

All literature can be made available in braille, large print or audio. To request a copy, please contact us using the details on the back page of this document.

Contents

1. Out-patient Plan cover

What's covered

The Out-patient Plan provides cover for consultations, diagnosis and a range of out-patient treatments. You have a choice of two annual cover limits. The limits are £2,000 or £5,000 each policy year.

All hospital treatment must be carried out at an eligible hospital. We have both a standard and an extended hospital list. You can only have treatment at hospitals on our extended list if you also hold our In/Day-patient plan and have selected the extended hospitals option. The list is published on www.nationalfriendly.co.uk/existing-customers (scroll down to 'Extended List') or it can be provided on request.

This is a summary of the cover available from the policy. Full details will be provided in your Policy Summary and Terms and Conditions documents.

What's covered under the Out-patient Plan	
Benefit	**Limitations of cover**
Private GP consultations which lead to a referral to a specialist.	
Private GP consultations which do not lead to a referral to a specialist.	We will pay for only one visit to a private GP per policy year which does not lead to a referral to a specialist, up to a maximum cost of £100.
Diagnostic consultations with a specialist.	
Diagnostic tests to find or help find the cause of your symptoms, including: • a range of camera-based investigations such as colonoscopies and endoscopies; • angiograms; • biopsies; • ECGs; • pathology tests; • scans (including MRI, PET, CT); • x-rays.	We do not pay for arthroscopies.
The following out-patient therapies before in/day-patient treatment of a medical condition: 1. acupuncture; 2. chiropractic treatment; 3. osteopathy; 4. physiotherapy.	We will pay for treatment for acute flare-ups of chronic conditions.

What's covered under the Out-patient Plan	
Benefit	**Limitations of cover**
The following therapies for the feet and lower limbs: 1. chiropody to treat medical conditions; 2. gait assessment; 3. podiatry to treat medical conditions.	
Minor surgery for the following out-patient treatments where medically necessary: 1. carpal tunnel decompression; 2. excision and cauterisation of cancerous tissue; 3. joint injections for tendonitis and bursitis.	We do not pay for these treatments for cosmetic reasons or under any other circumstances.
Mental health cover: 1. one initial psychiatric assessment per policy year, carried out on an out-patient basis; and 2. up to 10 face-to-face sessions per policy year with a counsellor or psychotherapist.	We do not pay for any subsequent psychiatric treatment.
Heart cover for the following: 1. angiograms; 2. biopsies; 3. blood tests; 4. ECGs.	We do not pay for angioplasty which is a day-patient or in-patient treatment.
Cancer cover for the following: 1. biopsies; 2. blood tests; 3. scans; 4. x-rays. required to diagnose your condition prior to active treatment.	We do not pay for: 1. genetic testing; 2. preventive treatments prior to diagnosis; 3. treatments after diagnosis; 4. screening.

What's not covered

This is a summary of the general exclusions from cover. Full details will be provided in your policy Terms and Conditions document.

1. accident and emergency admissions;
2. addiction-related medical conditions;
3. age-related medical conditions;
4. AIDS/HIV;
5. allergies;
6. chronic (long-term and incurable) conditions;
7. complementary medicine;
8. congenital conditions;
9. corrective treatment (for previous treatment not covered by your policy);
10. criminal activity and public order offences resulting in treatment;
11. cruise ship treatment;
12. developmental/behavioural conditions;
13. dialysis;
14. elective treatment;
15. epidemics;
16. experimental treatment;
17. fertility treatment;
18. gender reassignment/sex change;
19. hospitals on the extended list*
20. medication and dressings for use at home;
21. psychiatric treatment;
22. missed appointments;
23. natural disasters;
24. overseas treatment;
25. physical aids and devices;
26. pre-existing conditions (see previous page);
27. preventive treatment;
28. rehabilitation, residence and recovery;
29. routine monitoring, tests and examinations;
30. screening;
31. second opinion we have not requested;
32. self-inflicted injury;
33. sexual health;
34. sleep disorders;
35. spa therapies;
36. sports and pastimes that are dangerous;
37. transplant operations;
38. war, terrorist acts and civil commotion;
39. weight loss treatment and obesity treatment.

*unless you also have the In/Day-patient Plan and select the extended hospitals option.

How we deal with pre-existing medical conditions

You will be given a choice whether to tell us about your pre-existing medical conditions, so that you will know right from the start of your policy which ones are covered.

Alternatively you have the choice of a moratorium which automatically excludes pre-existing medical conditions for a period of time. A pre-existing condition might be covered in future if it doesn't recur within a set timeframe, although any recurrence could mean that timeframe starts all over again.

Whichever you choose, if we are prepared to cover you for any pre-existing medical conditions, this will be to the extent shown in this Policy Summary, and in more detail in the Terms and Conditions document.

2. How the policy works

Applying for a policy

Who can apply

You can apply for the Out-patient Plan if you are:

- between the ages of 18-75. A parent or guardian over the age of 18 can also apply for a policy on behalf of a child; and
- a permanent resident of the United Kingdom (excludes the Channel Islands and the Isle of Man)

The policy term

The Out-patient Plan runs for a five-year term.

Your choice of application

There are three ways you can apply.

1. Full medical underwriting

This might be suitable for someone who wants clarity on whether a pre-existing condition will be covered. We will tell you if a pre-existing condition is excluded from cover.

On your application form you provide us with details of medical conditions which you have been aware of, or had signs or symptoms of, or undergone consultations, investigations, medication, advice or treatment for, in the last five years. We will tell you whether we are prepared to offer you cover for those conditions. You can then choose whether to accept cover on that basis. Your Policy Schedule will specify which conditions are not covered (excluded) or which are covered only to a limited extent.

2. Continued personal medical exclusions

This application might be suitable for someone who:

- is applying to carry forward existing exclusions from a current private medical insurance policy to the Out-patient Plan; and
- wants clarity on whether a pre-existing medical condition will be covered under the Out-patient Plan.

On your application you will provide us with some details about your medical conditions for which you have received treatment in the last two years.

We will also ask you if you have had discussions with your GP, or plan to have discussions with your GP, which has or might lead to a consultation with a specialist.

If any medical conditions are not covered (excluded) under your current policy these exclusions will continue under the Out-patient Plan. We will also tell you whether we are prepared to offer you cover for any pre-existing medical conditions. You can then choose whether to accept cover on that basis. Your policy schedule will specify which conditions are not covered (excluded) or which are covered only to a limited extent.

3. Moratorium

This might be suitable for someone who has not had signs and/or symptoms of a pre-existing medical condition in the last five years before applying for the policy.

On your application you do not provide us with any details of your medical history. Any medical conditions which you have been aware of, or had, signs or symptoms of, or undergone consultations, investigations, medication, monitoring, advice or treatment for, in the last five years will not be covered for at least the first two years of the policy. If you do not have any signs or symptoms of a pre-existing medical condition in any two year period of the policy then any cover for that condition will be provided in line with the terms and conditions of this policy, from that point on.

Your choice of annual cover limit

You can choose an annual cover limit of £2,000 or £5,000, which will be refreshed at each policy anniversary. Your premiums will be higher if you choose the £5,000 annual cover limit.

Your choice of excess

You can choose to pay an optional excess towards the cost of claims in any policy year. The three excess options are: no excess, £100 and £250.

Your premiums will be lower the higher the level of excess you choose.

Private hospitals - extended list

You have a wide choice of hospitals you can use. We do not pay for treatment at a hospital on the extended list, unless you also take out our In/Day-patient Plan and select the extended hospitals option.

- Cromwell Hospital, London;
- The London Clinic;
- Harley Street at UCH, London;
- Harley Street Clinic, London;
- King Edward VII's Hospital – Sister Agnes, London;
- Lister Hospital, London;
- London Bridge Hospital, London;
- Portland Hospital for Women and Children, London;
- Princess Grace Hospital, London;
- Wellington Hospital, London.

These hospitals can be included on your Out-patient Plan if you also elect to take out our In/Day-patient Plan and choose the extended hospitals option. The extended hospitals option includes treatment at any UK private hospital, including those hospitals listed above.

You can only choose the extended hospitals option when you first take out our In/Day-patient Plan and you will be given the option to change your choice at each five-year renewal. A change to your hospitals option choice will be subject to underwriting review.

We will always endeavour to give you as wide a choice as possible. Occasionally, we may add to or reduce the list above. If we do so, it is always in our members' best interests. The up-to-date list is published on www.nationalfriendly.co.uk/existing-customers (scroll down to 'Extended list') or it can be provided on request.

Our approach to claims

Our aim is to make the claims process easy and straightforward. When you want to make a claim simply call us for authorisation using the details on the back page of this document. We'll explain what you can claim for and be on hand to answer any questions you have and guide you on your options throughout your claim. Full details of how to claim will be included in your policy Terms and Conditions document.

For eligible claims relating to diagnostic consultations and out-patient treatment you will need a referral from an NHS or private GP. For eligible claims relating to chiropractors, physiotherapists and mental health services you do not need to obtain a referral from your GP if you have had authorisation from our claims team.

Where we need confirmation or evidence to support your claim we will ask you for permission to obtain this from your GP, specialist or treatment provider. All hospital treatment must be carried out at an eligible hospital.

Eligible claims are covered up to your selected annual cover limit of £2,000 or £5,000, for treatment undertaken in each policy year in addition to any excess you choose to pay.

For example, if you have a £2,000 annual cover limit, £250 excess and your eligible claim costs £2,250, in that policy year you will pay the first £250 and we will pay the remaining £2,000.

This level of cover will be refreshed at each policy anniversary until the end of the policy term. If your treatment carries on into the next policy year another excess will apply.

You will not have to pay an excess towards the cost of private GP consultations.

Please note that you cannot carry forward, or back, any unused cover from any policy years.

Eligible claims will be paid providing they are within your annual cover limit and do not exceed the financial limits specified in our Schedule of Fees, which is published on our website and can be provided on request.

Schedule of fees

We set fee guidelines for how much we will pay for consultations and procedures. This helps us manage the costs of your private healthcare for the benefit of all our customers. Occasionally specialists might charge more in fees than we will cover under the policy, and if that's the case we'll work with you, either so that you pay the difference, or we will help you find an alternative specialist within our fee guidelines. You can see our up-to-date Schedule of Fees on our website on the 'Existing customers' page, or ask us for details.

Premiums and premium reviews

Your premiums

You can choose to pay your premiums monthly or annually. Premiums are payable by direct debit and include insurance premium tax at the current rate. Should the rate of insurance premium tax change we will update your premium to reflect this.

If you would like to change the frequency of your premium payments (i.e. monthly to annually or annually to monthly) you can do this at the policy anniversary.

Details of your premium will be provided on any quotation you receive and on your Policy Schedule.

It is important that you keep your premium payments up to date to maintain cover under your policy. If you don't you will not be able to claim and if your policy is three months in arrears, it will be closed.

Annual premium reviews

Premiums will be reviewed each year until the end of the policy term and will take into account:

- the annual cover limit you chose; and
- the standard premium for your age at the policy renewal date; and
- any excess you choose; and
- the extended hospitals option where you chose it; and
- the expected future frequency and value of all claims on policies which operate under the same terms and conditions as your policy; and
- changes in other factors such as taxation, regulation, National Friendly's costs or any other factor that we have reasonable grounds to believe will change the expected future profitability of the Out-patient Plan, as relevant to your policy, from the level anticipated when the premium rates were originally set.

The annual premium review could result in your premium rising, falling or staying the same. Any changes to your premium as a result of the premium review will take effect on each anniversary of your policy. We will write to you in good time to notify you before any changes are made to your direct debit.

Before your annual premium review you have the option to choose whether to keep your excess at the same amount or to increase it, in order to lower the amount of your new premium for the upcoming policy year. You will not be able to decrease your excess to a lower amount.

You cannot change your annual cover limit at the annual premium review. You can only change it at the five-year renewal.

3. Your information and rights

Your right to change your mind

You have the right to cancel your policy within 30 days of receiving your policy documents. If you decide it isn't right for you please contact us with your instruction to cancel. You will receive a full refund of any premium paid, provided you have not made a claim in that time.

What happens when you reach your five-year renewal

The Out-patient Plan is a five year contract that will be renewed every five years and will continue until:

- you stop paying premiums;
- you cease to live in the UK;
- you die;
- the policy is no longer available.

We will write to you, in good time before each fifth anniversary, to let you know the proposed terms of your cover including the premium, which will take account of the standard premium rate at the time for your selected annual cover limit, your age and any excess you chose. The five-year renewal is the only point at which you can change your annual cover limit.

The cover that we offer at your renewal date may have exclusions for specific medical conditions or, as an alternative, with an increase to our standard premium rates to take account of your health at that time and any claims that you made during the term of the policy.

If the Out-patient Plan is no longer available, we will do our best to offer you an alternative.

How to make a complaint

We always do our best to provide a high standard of customer care, but if something goes wrong please tell us so we can put it right. You can contact us using the details below. We will give you a copy of our leaflet 'How to make a complaint' explaining how we deal with complaints. This leaflet is also available at any time to view or download from our website.

Telephone:
0333 014 6244 Calls from UK landlines and mobiles cost no more than a call to an 01 or 02 number and will count towards any inclusive minutes.
8am-6pm Monday to Friday. Calls are recorded for training and quality purposes.

Email:
complaints@nationalfriendly.co.uk

Post:
Customer Services Manager
National Friendly
11-12 Queen Square
Bristol
BS1 4NT

We will investigate your complaint and try to resolve it promptly to your satisfaction. We aim to resolve complaints and send you our final response in writing within three business days, or within four to eight weeks for more complex complaints.

If you are not satisfied with our final response you may have the right to take your complaint to the Financial Ombudsman Service. This service is free and using it in no way affects your legal rights.

You can find more information on their website: www.financial-ombudsman.org.uk

Our regulators

National Friendly is the trading name of National Deposit Friendly Society Ltd which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Our Financial Services Register number is 110008.

You can check this at: https://register.fca.org.uk

The Financial Services Compensation Scheme (FSCS)

You are covered by the FSCS and may be entitled to claim compensation from them if we cannot meet our liabilities. Details can be found on their website: www.fscs.org.uk

Alternative formats

All literature can be made available in braille, large print or audio. To request a copy, please contact us using the details on the back page of this document.

Contact information

For information on setting up this policy please contact your healthcare intermediary. Alternatively you can call us on:

0333 014 6244 Calls from UK landlines and mobiles cost no more than a call to an 01 or 02 number and will count towards any inclusive minutes. Lines are open 8am-6pm, Monday to Friday excluding bank holidays. Calls are recorded for training and quality purposes.

Or email us on:
info@nationalfriendly.co.uk

Or visit us at:
www.nationalfriendly.co.uk

Or mail us at:
11-12 Queen Square, Bristol BS1 4NT

National friendly

Financial Ombudsman Service

OPP PS 08.20