National Friendly

My PMI

Policy Summary

Private medical insurance
that's just right for you

keyfacts®

Welcome to a different type of private medical insurance

My PMI is a simpler, friendlier way to get the level of private medical insurance cover that's right for you.

With different cover options to choose from, our private medical insurance is designed to suit people's different needs and budgets.

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Why take out private medical insurance?

Since its introduction back in 1948, the NHS has been looking after an increasing population.

The pandemic created a backlog of missed appointments, so now even more people are waiting for treatment.

Products like private medical insurance can help ease the burden by providing an option to waiting.

A little about us

National Friendly is a friendly society and mutual insurer that's over 155 years old. As we don't have shareholders, our focus is on our members and doing what's best for them.

Mutuality is all about working together to a common purpose. By consistently developing new products and providing high quality levels of service, we've built long-term relationships with members.

While we embrace technology and accept its uses, we know that there are times when you will want interaction with a human being who is sympathetic to your needs, especially when you have a medical issue. My PMI is another innovation that puts you at the heart of everything we do.

We've got you covered

My PMI allows you to choose very simply between four different levels of cover, so you get the right cover to suit your specific needs.

This guide explains the four levels of cover. Please read everything through before deciding whether to apply for one of these options. Remember, this is just a summary of the cover provided at each level, how you might apply and how we deal with claims; helping you decide if one of these levels of cover is right for you.

Choosing and reviewing your cover

My PMI is designed to provide quick access to a range of private healthcare services. It is generally suitable if you're looking to complement the cover provided by the NHS, and can afford to pay the regular premiums for cover.

While we provide information about our products, we do not provide advice as to whether it is suitable for you. You may get that type of advice from a specialist adviser, who will provide you with their own demands and needs statement.

Full terms of the policy can be provided to you separately. You'll also receive a Policy Schedule should you choose to take out a policy; this will contain details of the choices you make, such as the excess you want to pay.

There will be an application process to take out a policy, involving a choice of how we assess any conditions you suffered from before you applied. This will enable us to set fair terms and premiums (this will be explained to you as part of the application process).

If you decide to take out a policy, we will offer you terms for 5 years at a time. This means you do not need to renew each year and that we won't add any special terms based on your claims experience during that period. You are still free to cancel at any time without penalty.

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

We will write to you each year to let you know your premium for the following year and to remind you of the cover you hold.

Our contact details are at the back of this guide if you need any further information. You may also wish to speak to a financial adviser.

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

Who can apply and be covered?

The policy can be taken out by:

- an adult on a single life basis
- as a couple (two adults)
- as an adult with one or more children
- as a couple with one or more children

All adults who apply to take out or be covered under the policy have to be between the ages of 18 and 85; and all children to be covered up to the age of 23.

All those covered must be permanent residents of the United Kingdom (excluding the Channel Islands and the Isle of Man). All those to be covered must, at time of application, have been registered continuously with a GP in the UK for a period of at least six months, and have access to and be able to provide their full medical records in English.

Each policy will have a designated policyholder who must be at least 18 years of age.

The maximum permitted number of children on any policy is 10; and they all have to live at the same address.

Children must exit a family policy no later than their 23rd birthday but are free to take out an adult policy any time from age 18.

Where a child covered under the policy is aged under 18, we will correspond with the policyholder until the child reaches 18 years of age.

We will correspond directly with any adult over age 18 about a claim they are making.

We will require medical details for children, but babies can be added within three months of their birth without medical information; though we would point out we do not pay for congenital disorders (issues they were born with).

Please note that few, if any, private hospitals treat children under the age of three.

Out-patient and in/day-patient treatments

We have four levels of cover to suit different needs and different budgets. Our policies between them cover out-patient treatments and in- or day-patient treatments.

Out-patient treatments

Out-patient treatments tend to come at the beginning of a medical condition. It's the point at which you may need to see a GP, a specialist or both, to determine what's wrong with you. They are appointment based and don't necessarily involve treatment in hospital. Often there will be tests that need to be carried out; and where a muscle or ligament is affected, you may need some form of therapy. Treatment of mental health can involve counselling and this would be treated as an out-patient treatment too.

So, out-patient treatment is a core benefit which is covered alone at Level 1, or in conjunction with in-patient treatment at Levels 3 and 4.

In-and day-patient treatments

In-and day-patient treatment will almost certainly require a hospital bed, so you'll need your pyjamas!

Operations, cancer treatment and follow-up treatments are all categorised as in-or day-patient procedures.

You can cover these alone on Level 2, or in conjunction with out-patient treatment under Levels 3 and 4.

Choosing where you get treatment

When you first develop a medical problem which causes you concern, you can use the policy to get advice from a GP – whether that's face to face or speaking online or over the phone.

That GP will assess you and if they determine you need tests or to see a consultant, they will refer you down one of these routes; that's when you will speak to a member of the claims team who will help you get the treatment you need.

Your hospital choice

When you apply, you will be asked to choose which hospital/provider option you want on your policy. We will always try to get you the very best treatment in your local area.

If you choose our **Guided** treatment option, then when your GP refers you for further treatment, you will ask them to write what is known as an open referral; i.e. it says you need to see a certain type of clinician like a gastroenterologist, but doesn't name anyone in particular. You will then share this with a member of our claims team who will be able to arrange your treatment for you.

Finding the right consultant first time can make an enormous difference to patient outcomes. We have access to a wide range of consultants and deal with all major hospitals. We will always look to find a consultant close to you; certainly no more than 30 miles from where you live but usually closer.

The team will be able to book appointments for you, so getting diagnosed and treated will be as seamless and stress-free as possible. If you choose the Guided treatment option as a Level 2 customer, where consultations and most out-patient benefits are not covered, you will still be required to contact our claims team at the start of your treatment path, even if you are funding consultation costs yourself. Our claims team will source the consultant you use, because covered tests, scans or treatments could result.

If you want **free choice** on where you go for treatment and/or who you see, then you can select one of two options.

- you can choose our **Standard** hospitals list, which just excludes a list of hospitals whose costs exceed those elsewhere in the country; or
- you can choose our **Extended** hospitals list, which allows you to use any recognised hospital facility in the country, including those excluded from the Standard list.

These are currently all to be found in Central London and are listed on the next page.

For the standard and extended hospitals lists, when you speak to us at the beginning of your claim, you can either choose your own consultant or go with the one we recommend, according to the choice you made on joining. At all times, we will be working with medical providers to get the best deals on treatment for our membership. That's part of being a mutual.

G Guided

S Standard

E Extended

Will we appoint a consultant who will oversee your care?

G – Yes, we select your provider and best course of treatment

S – No, you/ your GP select(s) provider

E – No, you/ your GP select(s) provider

Will we book your appointments for you?

G – Yes

S – No

E – No

Hospitals at which you can get treatment?

G – Hand-picked by our claims team

S – All except the most expensive

E – All

Private hospitals – extended list

All HCA hospitals including:
- Harley Street at UCH
- Harley Street Clinic
- Lister Hospital
- London Bridge Hospital
- Portland Hospital
- Princess Grace Hospital
- Wellington Hospital
- Chiswick Medical Centre
- LOC Main Clinic, Harley Street
- HCA UK at University College Hospital
- HCA UK at The Shard
- HCA UK City of London
- Golders Green Outpatients & Diagnostic Centre
- Sydney Street Outpatients & Diagnostic Centre

PLUS:
- The Cleveland Clinic
- Cromwell Hospital
- The London Clinic
- King Edward VII's Hospital - Sister Agnes

Manchester:
- All HCA hospitals including:
- The Christie Private Care, Wilmslow
- HCA UK at The Wilmslow Hospital

Some of the hospitals listed have multiple clinics under separate names and these will similarly be excluded unless you have selected and paid for our Extended option. 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 our website, or it can be provided on request.

Access to private GP services

Whichever level of cover you choose, your policy comes with access to our virtual GP service. It's called Friendly GP and it can be accessed over the phone or online 24 hours a day, 7 days a week.

The service includes:

- 24/7 GP telephone consultations
- video consultations
- private prescriptions
- open referrals

Our 4 levels of cover

LEVEL 1

If your key area of concern is getting quick diagnosis and out-patient treatment, then our Level 1 cover could be right for you. This is typically the cheapest of our four levels, and offers access to private GPs and consultants, scans, tests and therapies, plus a few minor operations and you will choose how much cover you want when you apply.

If you want cover for both out-patient and in-patient treatments, then check out our Level 3 and Level 4 policies.

LEVEL 2

If you're happy to pay for out-patient treatment yourself, then our Level 2 policy may be an option for you.

It pays an allowance towards scans and tests, but focuses on more expensive treatments, typically for cancer and operations. These are known as day-patient treatment or in-patient treatments and cover for these is £1 million a year. If you want cover for both out-patient and in-patient treatments, then Level 3 or Level 4 may be of interest to you.

LEVEL 3

Level 3 has the same out-patient diagnostic and treatment cover as Level 1, limited to £2,000 or £5,000 each year, plus up to £1 million a year in-and day-patient cover for operations and cancer treatments, broadly similar to the cover offered under Level 2.

LEVEL 4

Level 4 has the same benefits as Level 3, but with no overall monetary limits for out-or in-patient treatment.

It also has a few additional benefits, with stem cell and bone marrow treatments permitted for cancer, and some value-added benefits not normally associated with private medical insurance such as health checks and taxi fares.

Level 1

Quick diagnosis and treatment can make all the difference

- This covers private diagnostics and initial treatments (out-patient benefits).
- You can choose how much cover you want in financial terms – that's either £2,000 or £5,000 each year.
- In the following pages you'll find a summary of the cover available with this policy. Full details will be provided in your Policy Schedule and Policy Conditions documents.

What's covered on Level 1	Limitations of cover
Face to face private GP consultations which lead to a referral to a specialist. For most, treatment will start with some sort of consultation with a GP, whether that's in person or on the phone, or even in a virtual environment. We will pay for such services and you can use our virtual GP service as part of your policy at any time without restriction.	None – other than the £ annual policy limit you choose.
Face to face 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.	By specialist, we mean one sourced and/or authorised by our claims team.
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 don't pay for the four listed therapies where these are delivered as follow-ups to in- or day-patient treatment. We will not pay for alternative therapies such as, but not limited to reiki and homeopathy.
The following therapies for the feet and lower limbs: 1. chiropody to treat medical conditions; 2. gait assessment; 3. podiatry to treat medical conditions.	We don't pay for cosmetic or cleansing treatments.
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 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?

There are a number of general exclusions from cover on all of our policies which you can find on page 22.

In particular, we would like to point out that we do not cover treatment for pre-existing medical conditions, or for those known to be chronic in nature, i.e. no treatment will cure it.

This policy is designed to cover out-patient treatments and so will not pay for operations or other in-patient treatments such as cancer after diagnosis.

The policy limits are £2,000 or £5,000 per person, per policy year. Any costs which exceed the level you choose, or where usage is outside of the terms described, will be your responsibility and yours to pay. We will explain this and help you when you claim.

Level 2

Access to private operations and cancer treatment

- This covers in-patient (hospital based) treatments to a limit of £1 million for each person on the policy per year. Other than scans and tests, minor operations and access to our virtual GP service Friendly GP, this policy doesn't cover the benefits of Level 1.
- This policy is designed to cover diagnostic scans and tests and hospital treatments after diagnosis.
- If you choose the Guided treatment option, you will still be required to contact our claims team at the start of your treatment path, even if you are funding consultation costs yourself. Our claims team will source the consultant you use, because covered tests, scans or treatments could result.
- In the following pages you'll find a summary of the cover available with this policy. Full details will be provided in your Policy Schedule and Policy Conditions documents.

What's covered on Level 2	Limitations of cover
Diagnostic tests and scans recommended by your GP or specialist. These include: **Scans** • camera-based investigations; • electrocardiograms (ECG); • radiology such as: – angiograms; – computerised tomography (CT) scans; – magnetic resonance imaging (MRI) scans; – positron emission tomography (PET) scans; – x-rays. **Tests** • removal of tissue; • samples for testing; • treadmill tests; • gait assessments.	We don't pay for diagnostic tests ordered by anyone other than a specialist or GP. We do not pay any associated GP's or specialist's consultation fee. We will only pay for the covered test or scan. Scans are limited to £1,500 per covered person in any policy year. Tests are limited to £1,000 per covered person in any policy year.
Private hospital in-patient and day-patient treatment costs: • pre-operative tests; • specialists' fees for surgery; • operating theatre costs; • medications and dressings necessary to aid your recovery as an in-patient or a day-patient; • hospital accommodation costs; • associated nursing care. Eligible treatment following on from NHS accident and emergency admission is covered only after you have first been medically discharged.	We do not pay for incidental costs that are unrelated to your treatment. We do not pay for medication and dressings for use at home.

What's covered on Level 2	Limitations of cover
NHS hospital stays: We will pay £100 a night for up to ten overnight stays per policy year in an NHS hospital where the treatment you are receiving was also available as a private patient.	This benefit is not available where you are also claiming the Fixed Cash Allowance (see P29).
Medical appliances or prostheses inserted or attached as part of a treatment we have authorised.	We do not pay for the supply or fitting of physical aids and devices such as hearing aids, spectacles or contact lenses, walking sticks, walking frames or crutches.
Dental procedures in a hospital for: • surgical removal of any impacted teeth or buried teeth or roots (including apicectomy); and the enucleation of cysts of the jaw.	We do not pay for any other dental procedures, such as but not limited to: • hygienist procedures; • orthodontics. We do not pay for any dental procedures in a dental surgery.
Eye treatment in a hospital for acute conditions where treatment leads to lasting recovery, such as cataract surgery.	We do not pay for refractive surgery or treatment for permanent eyesight damage or deficiency.
Treatment in a hospital for the repair of a perforated eardrum.	We do not pay for any other aural procedures or for treatment of deafness.
Hospital accommodation costs when accompanying a child policyholder who is receiving eligible treatment under this policy.	We do not pay for incidental costs that are unrelated to the child's treatment.
Private land ambulance where medically necessary.	
Home nursing under the instruction and supervision of your specialist for eligible covered treatment which follows on from an authorised in-or day-patient treatment.	Limited to six months for any claim.
Tonsillectomy/adenoidectomy where deemed medically necessary to resolve a medical condition.	We do not pay for preventive measures.
Varicose vein treatment where you have or are about to have, a venous ulcer.	We do not pay for treatment of thread veins or superficial veins.
Treatment for the following complications where you have arranged to pay for your child's birth in a private hospital; • emergency caesarean section; • retained placental membrane; • ectopic pregnancy; • stillbirth; • hydatidiform mole; • post-partum haemorrhage.	You are not covered for the listed treatments within the first twelve months of your policy. We do not pay for any other treatment of medical conditions relating to pregnancy. We don't pay for treatment of the baby after birth.

What's covered on Level 2	Limitations of cover
Fixed Cash Allowance – cash sum payable as alternative to eligible private in-patient operations, known as a fixed cash allowance, where: • the treatment is covered by your policy and is pre-authorised; and • you choose instead to have your treatment performed on the NHS; and • you have sufficient annual allowance remaining to cover the full cost of the private treatment.	Minimum operation costs apply. Please visit www.nationalfriendly.co.uk/existing-customers under the heading Fixed Cash Allowance.
Cosmetic and aesthetic treatment: We will cover reconstructive surgery which we have authorised in advance to restore function or appearance following an accident or covered surgery which took place after this policy started.	We do not pay for any other procedures to change physical appearance such as but not limited to: facelifts, breast reduction or augmentation or tummy tucks; removal of tissue which is not diseased, such as but not limited to removal of surplus fat or healthy tissue, for example warts and verrucas; removal of, or treatment of infections caused by, tattoos.
Heart treatment: • coronary angioplasty; • coronary artery bypass; • fitting of pacemaker/ defibrillator; • cardiac valve surgery.	We do not pay for: • routine heart and circulatory checks • maintenance or replacement of pacemakers, defibrillators and other heart-related devices once inserted.
Cancer treatment: • chemotherapy, including home treatment where deemed medically necessary by your specialist; • radiotherapy; • medications prescribed by your specialist to help alleviate cancer-related bone damage and side effects of chemotherapy; • wigs purchased as a result of hair loss caused by cancer treatment; • prostheses which are provided as part of active treatment of your cancer; • consultations during active treatment. Treatment can be administered at a private hospital, day-patient unit or scanning centre or in your own home, care home or nursing home where administered by a healthcare professional under guidance from your cancer specialist.	We do not pay for: • preventive treatment; • experimental treatment; • clinical trials; • biological therapies; • stem cell or bone marrow treatment or research; • genetic testing or screening; • transport costs relating to cancer treatment; • out-patient medication and dressings prescribed by your GP; • supportive, palliative or hospice care; • treatment given solely to relieve symptoms. Wigs are covered to a total of £400 each policy year.

What's covered on Level 2	Limitations of cover
Follow-up consultations within six months of your treatment which are required to complete the recovery process. Cover includes: • your specialist's fees for follow-up consultations and tests; • removal of stitches or casts; • medication and dressings administered or applied before leaving hospital.	Follow-up consultations are covered to a total of £500 each policy year. We do not pay for medication and dressings for use at home. We do not pay for routine monitoring after stabilisation.
Follow-up therapies which are required to complete the recovery process until your medical condition is stabilised. We cover: • acupuncture; • chiropody; • chiropractic; • osteopathy; • physiotherapy; • podiatry; where you are referred by a specialist and within six months of your treatment.	Follow-up therapies are covered to a total of £500 each policy year. We do not pay for routine foot care which is not medically necessary such as: • fungal disorders; • cutting or removal of blisters, corns and calluses; • cosmetic foot care and pedicures. We do not pay for insoles, hosiery or footwear.

What's not covered?

There are a number of general exclusions from cover on all of our policies, which you can find on page 22.

In particular, we would like to point out that we do not cover treatment for pre-existing medical conditions, or for those known to be chronic in nature, i.e. no treatment will cure it.

This policy is designed to cover chiefly in-patient treatments, and so will not pay for diagnostic consultations or other out-patient treatments, such as physiotherapy, which take place prior to hospital treatment. It does not cover mental health treatment.

Level 3

Treatment as well as diagnosis at a reasonable price

- This covers both out-patient and in-patient (hospital-based) treatments.
- This policy has the same limits and benefits as our **Level 1 policy**, plus the in-and day-patient benefits listed below which have a limit of £1 million for each person on the policy per year.
- In the following pages you'll find a summary of the cover available with this policy. Full details will be provided in your Policy Schedule and Policy Conditions documents.

What's covered on Level 3	Limitations of cover
Private hospital in-patient and day-patient treatment. This includes: • associated nursing care; • drugs and dressings necessary to aid your recovery while a day-patient or in-patient; • hospital accommodation costs; • investigative procedures such as keyhole surgery and arthroscopy; • operating theatre costs; • pre-operative tests; • specialist fees for surgery, anaesthesia and physicians' fees. **NHS hospital stays** We will pay £100 a night for up to ten overnight stays per policy year in an NHS hospital where the treatment you are receiving was also available as a private patient.	We do not pay for incidental costs that are unrelated to your treatment. We do not pay for medication and dressings for use at home. This benefit is not available where you are also claiming the Fixed Cash Allowance (see P39).
Follow-ups and monitoring after surgery. This includes: • follow-up consultations, tests and x-rays; • out-patient drugs and dressings administered or applied immediately after surgery; • out-patient treatment essential to your recovery from a covered in-patient treatment such as physiotherapy following an operation on a limb joint; • removal of stitches and casts. All of the above will continue to be covered until your condition has stabilised.	We do not pay for: 1. out-patient drugs and dressings for use at home; 2. routine monitoring after stabilisation.

What's covered on Level 3	Limitations of cover
Medical appliances and prostheses fitted, inserted or attached as part of a medical procedure.	We do not pay for incidental costs that are unrelated to your treatment. We do not pay for medication and dressings for use at home.
Dental procedures in a hospital for: 1. enucleation of cysts of the jaw; 2. surgical removal of impacted teeth, buried teeth or roots.	We do not pay for treatment at a dental surgery. We do not pay for any other dental procedures, such as but not limited to: • hygienist procedures; • orthodontics.
Eye treatment in a hospital for acute conditions where treatment leads to lasting recovery such as cataract surgery.	We do not pay for: 1. corrective treatment for short sight or long sight such as laser eye surgery; 2. treatment for permanent eyesight damage such as the purchase of glasses or contact lenses.
Aural procedures in a hospital for the repair of a perforated eardrum.	We do not pay for: • transplants, such as cochlea transplants; • hearing aids or devices; • any other aural procedure.
Hospital accommodation costs incurred by the parent or guardian named on the application form when they stay with a child policyholder who is receiving treatment covered by this policy.	
Private land ambulance where medically necessary	
Tonsillectomy/adenoidectomy where medically necessary	We do not pay for any preventive measures.
Varicose vein treatment for venous ulcer treatment.	We do not pay for treatment of thread veins or superficial veins
Subsequent treatment for the following where you have arranged to pay for your child's birth in a private hospital: 1. ectopic pregnancy; 2. emergency caesarean section where, for medical reasons presenting risk to the life of the baby or its mother, the baby needs to be delivered early; 3. hydatidiform mole; 4. post-partum haemorrhage; 5. retained placental membrane; 6. stillbirth.	You are not covered for the listed treatments in the first 12 months of your policy. We do not cover treatment of your baby after birth. We do not pay for any other treatment of medical conditions relating to pregnancy.

What's covered on Level 3	Limitations of cover
Cosmetic and aesthetic treatment: We will cover reconstructive surgery which we have authorised in advance to restore function or appearance following an accident or covered surgery which took place after this policy started.	We do not pay for: any other procedures to change physical appearance such as but not limited to: facelifts, breast reduction • or augmentation or tummy tucks; • removal of tissue which is not diseased, such as but not limited to removal of surplus fat or healthy tissue, for example warts and verrucas; • removal of, or treatment of infections caused by, tattoos.
Fixed Cash Allowance – cash sum payable as alternative to eligible private in-patient operations, known as a fixed cash allowance, where: • the treatment is covered by your policy and is pre-authorised; and • you choose instead to have your treatment performed on the NHS; and • you have sufficient annual allowance remaining to cover the full cost of the private treatment.	Minimum operation costs apply. Please visit www.nationalfriendly.co.uk/existing-customers under the heading Fixed Cash Allowance.
Cover for heart operations/ procedures Heart cover for: 1. cardiac valve surgery; 2. coronary angioplasty; 3. coronary artery bypass; 4. implementation of devices such as a pacemaker or defibrillator. Scans and tests requested by your specialist after diagnosis of a medical condition has been established. Monitoring until your medical condition has been stabilised.	We do not pay for: • routine heart and circulatory checks such as but not limited to monitoring blood pressure; • the maintenance or replacement of pacemakers, defibrillators and other heart-related devices once inserted.

Benefits and Limitations for Level 3 – Cancer Cover		
Benefit	**Extent of Cover**	**Limitations of Cover**
Cancer treatment	We will pay for the following treatment intended to affect the growth of the cancer by shrinking the cancer, or stabilising it to slow the spread of the disease: • conventional surgery for the treatment of cancer • chemotherapy, including home treatment where deemed medically necessary by your specialist; • immunotherapy (monoclonal antibodies); • hormonal therapy where this is to shrink a tumour before you have surgery or radiotherapy; • targeted therapy (tyrosine kinase inhibitors); • radiotherapy; • medications prescribed by your specialist to help alleviate cancer-related bone damage and side effects of chemotherapy. All cancer drugs must be approved and licensed by The Medicines and Healthcare products Regulatory Agency (MHRA) and/or NICE (The National Institute of Health and Care Excellence). All such drugs must be used according to that licence, including those on phase III clinical trials. • wigs purchased as a result of hair loss caused by cancer treatment up to a maximum of £400 per policy year; • prostheses which are provided as part of active treatment of your cancer. Treatment can be administered at a private hospital, day-patient unit or scanning centre or in your own home, care home or nursing home where administered by a healthcare professional under guidance from your cancer specialist. An example might be administering intravenous drugs.	We do not pay for: • preventive treatment; • experimental treatment of any type; • clinical trials other than listed; • biological therapies other than those listed; • hormonal therapies other than listed; • stem cell and bone marrow treatment; • gene therapy, genetic testing or screening; • administration or transport costs relating to cancer treatment; • out-patient medication (such as but not limited to hormone replacement therapy) prescribed by your GP. • palliative or end of life care If your cover level does not pay for your particular treatment our claims team will work with you to discuss your options.

Level 4

Full package of benefits plus extra service

- This covers both out-patient and in-patient (hospital-based) treatments.
- The policy covers all of the benefits from our Level 3 policy, plus the additional benefits and services listed.
- The key difference from Level 3 is that these benefits have **no cash limitations** unless otherwise stated.
- This is a summary of the cover available from the policy. Full details will be provided in your Policy Schedule and Terms and Conditions documents.
- The features table shows benefits **additional** to those covered under Level 3.
- In the following pages you'll find a summary of the cover available with this policy. Full details will be provided in your Policy Schedule and Policy Conditions documents.

What's covered on Level 4	Limitations of cover
Cancer cover	We will pay for stem cell or bone marrow treatment medically necessary to assist in treatment of cancer. We will also pay for palliative (end of life) care.
Concierge option – travel	Where you require a covered treatment which requires you to be sedated, we will pay your taxi fare to and/or from the hospital or treatment facility. Maximum of £50 per journey
Concierge option – second opinion	Where we are satisfied a second medical opinion is required to reach a firm diagnosis or to determine your best course of treatment, we will pay for this.
Women's health benefit	We will pay for a maximum of three consultations over the course of each 5-year term where these are designed to provide advice on wellbeing. This covers advice and testing at stages of the menopause, and will take in tests for your general health such as cholesterol levels. The allowance for each consultation carries a maximum of £300.
Men's health benefit	We will pay for a maximum of three consultations over the course of each term where these are designed to provide advice on wellbeing. This covers advice and testing such as PSA (Prostate Specific Antigen) tests, and will take in tests for your general health such as cholesterol levels. The allowance for each consultation carries a maximum of £300.
NHS hospital stays	We will pay £100 a night for up to twenty overnight stays per policy year in an NHS hospital where the treatment you are receiving was also available as a private patient.

Our cancer cover

Level 1

Covers cancer only, as far as diagnosis (£2k or £5k annual limits).

Level 2

Covers diagnosis (scan and test only); then provides a limited level of chemo/radiotherapy, but no biological/stem cell/bone marrow therapies.

Level 3

Covers diagnosis within £2k or £5k annual limits, then in-patient to include chemo-, radio- and biological therapies, to a £1 million annual limit.

Level 4

Covers diagnostics, radio-, chemo-, biological, bone marrow and stem cell therapies, without financial limits.

How we help with a cancer diagnosis

Our Level 4 policy will pay for all costs associated with diagnosis, the consultations you attend and:

- subsequent treatment as listed. We pay for all major conventional treatments for cancer, which include surgery, chemotherapy, radiotherapy and the transplantation of stem cells and bone marrow where appropriate.
- If there are side effects as a result of the treatment, these will be covered under the policy.
- If your treatment needs to be administered at home, we will pay for this too.
- We will pay for treatment while this remains effective in controlling the growth rate of the disease.
- We will pay for follow-up treatment and consultations with a specialist, which check your recovery and the absence of cancer until such time as your condition is stabilised. We don't set a time limit.

Covered treatments, medical providers and terms

The cover we offer for any given level will be diagnostic procedures and treatments which are

- recognised as effective by the UK medical profession and its professional bodies, such as the National Institute for Health and Care Excellence (NICE) and/or the Medicines and Healthcare products Regulatory Agency (MHRA).
- We will cover only those medical providers and hospitals which meet the professional standards we set out.
- We will cover only consultations, diagnostic procedures and treatments we have authorised in advance and agreed you can proceed with.

For the other levels, there are limitations to what we pay, as set out below:

Feature	Covered on	Restrictions	Comment
Diagnostic tests, scans and consultations	All Levels	Out-patient limits of £2,000 or £5,000 apply on Levels 1 & 3. Scans (£1,500 and Tests (£1,000) limited on Level 2 (no consultation benefit)	On Level 2, policyholders are responsible for paying for any consultation fee which accompanies covered scans/ tests.
Conventional surgery you require and any reconstructive surgery which is necessary as a result	Levels 2, 3 and 4		
Licensed* drugs	Levels 2, 3 and 4		*medications approved and licensed by The Medicines and Healthcare products Regulatory Agency (MHRA) and/or the National Institute for Health and Care Excellence (NICE), to include drugs which are prescribed by your specialist to help alleviate cancer-related bone damage and side effects of chemotherapy. All such drugs must be used according to that licence.
Radiotherapy	Levels 2, 3 and 4		
Biological drugs and treatments to destroy or shrink cancer cells, such as hormonal treatment or immunotherapy	Levels 3 and 4		
Phase III clinical trials	Levels 3 and 4		
Consultations during and after your treatment	Levels 2, 3 and 4		

For the other levels, there are limitations to what we pay, as set out below:

Feature	Covered on	Restrictions	Comment
Home treatment where deemed medically necessary by your specialist, for example to administer drugs intravenously	Levels 2, 3 and 4		
Stem cell and bone marrow treatment	Level 4 only		
Wigs purchased as a result of hair loss caused by cancer treatment	Levels 2, 3 and 4	Max £400 in any policy year	
Prostheses which are provided as part of active treatment of your cancer	Levels 2, 3 and 4		
Palliative care	Level 4 only	We will pay for palliative treatment to help relieve symptoms and manage pain and will pay £500 to a cancer charity involved in your treatment	Palliative care is where your cancer cannot be controlled.

What's not covered

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

- Accident and emergency treatments
- Addiction to, or abuse of drugs, substances or alcohol
- Age-related medical conditions for things everyone goes through (e.g. puberty)
- Allergies
- Chronic conditions (where treatment is solely provided to relieve your symptoms – see page 23)
- Complementary medicine (other than acupuncture)
- Congenital conditions (conditions you were born with)
- Corrective treatment
- Criminal activity and public order offences in which you played an active role
- Cruise ship treatment (even in UK waters)
- Developmental/ behavioural conditions, including but not limited to dyslexia and dyspraxia, ADHD (attention deficit hyperactivity disorder), Asperger syndrome and autism
- Developmental/ behavioural conditions, including but not limited to dyslexia and dyspraxia, ADHD (attention deficit hyperactivity disorder), Asperger syndrome and autism
- Dialysis
- Elective treatment (not recommended by your specialist)
- Epidemics/ Pandemics
- Experimental treatment
- Fertility treatment
- Gender reassignment/ gender confirmation/ sex change
- Medication and dressings for out-patient/ take home use
- Mental health/ psychiatric treatment as an in- or day-patient
- Missed appointments
- Natural disasters
- Overseas treatment
- Physical aids and devices
- Pre-existing conditions excluded under the terms on which you joined
- Preventive treatment
- Rehabilitation, convalescence, residence and recovery
- Routine monitoring, tests and examinations
- Screening where no symptoms exist (outside of the Men's/ Women's health allowance)
- Second opinions we have not pre-authorised
- Self-inflicted injury
- Sexual health, either sexually-transmitted disease or problems relating to sexual dysfunction
- Sleep disorders
- Spa therapies
- Transplant operations
- Treatment resulting from injuries sustained in sports for which you receive reward or which pose excessive claims risk
- Vaccinations or other preventive injections
- War, terrorist acts and civil commotion
- Weight loss treatment and obesity treatment

Chronic conditions

It's important that we explain what we mean by chronic conditions.

A chronic condition is one which has one or more of the following characteristics:

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

This means that, while there may be treatments to keep symptoms under control, there is no lasting cure for them. The NHS is the best source of treatment for chronic conditions, so we don't generally cover them. We cover what are known as acute conditions, likely to respond quickly to treatment and where treatment aims to return you to the state of health you were in before or which leads to your full recovery.

We also pay for diagnosis of medical conditions and so will pay for tests which lead to the conclusion that a condition is chronic in nature but cover for them stops after diagnosis.

Exceptions

Where a chronic condition gets markedly worse and you need a short-term (acute) treatment to get you back to the state of health you were in before, we will consider the authorisation of such treatment, and, where this stabilises the condition, will pass you back into NHS care and treatment.

If your treatment is urgent rather than something you have time to arrange, you should use the NHS emergency services in the normal way.

Claiming on the policy

The important thing is to get us involved in the process as soon as possible. We can then make accessing diagnosis and/or treatment as quick and smooth as possible.

You need to get our authorisation to proceed with treatment, but it also makes sense to do so as soon as possible because we can use our experience to get you the right treatment from the right source.

Whilst you can choose on joining to go where you want for treatment, the strength of this policy is in our ability to get you to the right treatment for your particular circumstances.

When you see your GP or use our virtual GP service they may well refer you for treatment.

You will then need to get your treatment authorised by our claims team. Where you go for treatment depends on the choice you make when you join.

If you select our guided treatment service, you can ask the GP to write what's known as an open referral in which they state that you need a specific type of consultant but don't name or organise that for you. That's where our claims team will find a specialist consultant for you.

If you choose our standard or extended hospital options when you join, you will be able to use hospitals under those definitions which you or your GP will arrange. You will still need our claims team to authorise such treatment before you go ahead.

We will then deal with your treatment provider as much as possible so you don't have to. To do this, we will need your medical consent.

If you choose a consultant/specialist other than one under the terms of the option you selected, you may be liable for some or all of the costs. You should check the Policy Conditions for further details.

Who we will speak to

We will speak to anyone aged 18 or over who is covered on the policy and who needs treatment.

So, when you have children covered on your policy, we will speak to their parent until they reach 18 then start speaking with them directly.

The treatment recommended for children may involve the NHS rather than a private source because they tend to have more specialists in this sphere but we will liaise with you on this to get them the best possible outcomes.

When a claim will end

A claim will normally end when your consultant is happy you need no further treatment, but it could also end if we do not get the information we need to authorise it, if your policy terms apply restrictions, or if the condition is diagnosed as chronic.

How to get in touch about your claim

Most people phone us – the number to call is **0333 014 6244**. We'll be on hand from 8am to 6pm Monday to Friday. Our calls are recorded.

If you need to email us with any information or documentation, our email address is **nfclaims@healix.com**

And if there's a bill or other piece of medical evidence you need to send us, our postal address is **National Friendly Claims Team, 3 Temple Quay, 5th Floor, Temple Back East, Temple Quay, Bristol, BS1 6DZ**

Don't forget!

If you need advice quickly, as a valid policyholder you can access our virtual GP service Friendly GP anytime day or night on **0333 015 0304**. 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.

Dealing with pre-existing conditions

When someone applies for a policy with us we need to write terms fair to them and to our other members. As part of that we need to determine on what basis we will cover medical conditions that person has suffered from in the past or indeed has now.

This is called underwriting and we have three forms of underwriting from which you will pick one. Where we say 'you' in this section, we mean you or any other person covered under your policy who has a pre-existing medical condition.

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.

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 your new policy; and wants clarity on whether a pre-existing medical condition will be covered under the new policy.

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 your policy with us. 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.

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 then have a period of two years in a row, after joining without any signs or symptoms of that pre-existing condition, and you have not undergone a consultation, any investigations, medication, monitoring, advice or treatment of that pre-existing medical condition during that two-year period, then any cover for that condition will be provided in line with the terms and conditions of this policy from that point on.

Premiums, reviews and renewals

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.

Paying an excess

An excess is an amount you agree each person will pay each policy year towards treatment costs covered under your policy.

So, for example, if you choose an excess of £250 and your first treatment in a policy year is £1,500, you will pay £250 towards that treatment and we will pay the remaining £1,250. We will pay all eligible costs for the remainder of that policy year.

The excess options for all four levels are: no excess, £100, £250, £500 and £1,000.

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

Annual premium reviews

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

- the standard premium for your age and postcode area at the policy review date; and
- any excess you choose; and
- the hospital/ provider choice you make 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 My PMI range, 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 help offset any rise in your new premium for the upcoming policy year. You will not be able to decrease your excess to a lower amount.

You will have the opportunity to change your hospital/ provider choice at an annual review once during each five-year period and must remain with that choice for the remainder of the five-year term. You will not be allowed to change your hospital/provider option to receive planned medical treatment.

Five-year renewal

Each policy from our range is a five-year contract that will be renewed every five years and will continue until you tell us otherwise. 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. If the type of policy you hold is no longer available, we will do our best to offer you a suitable alternative.

Your policy will only end if:

- you close the policy;
- we close it under the terms of The Consumer Insurance (Disclosure and Representations) Act 2012;
- you stop paying premiums;
- you cease to live in the UK;
- you die;
- the policy is no longer available.

Further information

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 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.

If you cancel after 30 days, we will pay back only overpaid annual premiums.

If you want to change your cover level at a later date, please contact us using the details on the back of this document and we will let you know what we need from you. Alternatively, please contact the person/ company that sold you the policy.

Your Policy Conditions will provide details of what happens if you want to change those covered by the policy.

How to make a complaint

We hope that you never have reason to complain about your policy or the service you receive from us. If you do, you have the right to complain and we would like to put things right.

You can tell us what's gone wrong by telephone, email or post.

- Phone us: **0333 014 6244** 8am-6pm Monday to Friday excluding bank holidays. 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.
- Email us: complaints@nationalfriendly.co.uk
- Write to us:
  Complaints Coordinator
  National Friendly,
  11-12 Queen Square,
  Bristol
  BS1 4NT

We will explain our complaints process, 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 we cannot resolve your complaint to your satisfaction, you may be able to refer your complaint to the Financial Ombudsman. This service is free and using it in no way affects your legal rights to take civil action. You can find out more information at www.financial-ombudsman.org.uk.

You can write to the FOS at **Financial Ombudsman Service, Exchange Tower, London E14 9SR**, phone them on: **0800 023 4567**, or email at:
complaint.info@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.

Full details of what you are protected for can be found at www.fscs.org.uk or by telephoning **0800 678 1100**. Alternatively you can write to them at:
The Financial Services Compensation Scheme,
PO Box 200, Mitcheldean
GL17 1DY.

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.

Here's how you can contact us

We're here to help

You can call us on:

0333 014 6244 8am-6pm Monday to Friday excluding bank holidays.

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. Calls are recorded for training and quality purposes.

Or email us at:

info@nationalfriendly.co.uk

Or visit us at:

www.nationalfriendly.co.uk

Or mail us at:

National Friendly
11-12 Queen Square, Bristol
BS1 4NT

National Friendly

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