Health Choices for Me

All you need to know

2013

EXETER FAMILY FRIENDLY

COVER excellence AWARDS 2012 winner

WINNER Investment Life & Pensions Moneyfacts Awards 2012

My Definitions

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

Acute

A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

Adult

We define an adult as someone who is 18 years or older.

Benefit

The amount that may be payable by us under the policy for any eligible claim.

Cancer

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

Chronic

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

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

Day-patient

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

Dependant

Any child for whom you or your partner holds the position of a legal guardian. You can include a dependant on your policy up to the annual renewal date following their 21st birthday, or 25th birthday if in full time education.

Diagnostic tests

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

Excess

The amount which will be deducted from the eligible benefits for each person, each policy year, in return for a reduced premium.

Fee Schedule

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

Heart condition

We define an applicant to have a heart condition if they are suffering from or have previously suffered from one or more of the following:

- Angina
- Heart attacks
- Disease of the heart valves
- Ischaemic heart disease
- Adult heart murmurs
- Congenital heart disease
- Heart arrhythmia or palpitations (irregular heartbeat)
- Cardiomyopathy

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

Home nursing

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

Hospice

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

Hospital List

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

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, eg shoe inserts, neck supports and wrist braces. Equipment must be for the purpose of aiding recovery rather than managing long-term conditions.

Non-smoker

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

Nurse

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

Out-patient

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

Plan

Health Choices for Me.

Policy

Our contract of insurance with you.

Policy Certificate

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

Policyholder

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

Pre-existing condition

Any disease, illness or injury, for which:

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

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

Premium

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

Renewal date

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

Specialist

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

Treatment

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

United Kingdom

Great Britain, Northern Ireland, Channel Islands and the Isle of Man.

We/Our/Us

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

Year

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

Welcome to Health Choices for Me

This is your policy document which contains the terms and conditions of our Health Choices for Me plan and everything you need to know about how the plan works. This document, together with your Policy Certificate and completed application, forms your policy with us.

Please take the time to read through this document. We have highlighted some features of the plan with a magnifying glass which we suggest you pay particular attention to. We have also included guidance and examples throughout the document to help you get the most from your policy.

Health Choices for Me is a private medical insurance plan that is designed to work alongside, not to replace, all of the services offered by the NHS and has been designed to give you quick access to private medical treatment in the UK when you need it.

Health Choices for Me allows you to tailor your cover according to your needs, so you can relax in the knowledge that you have covered the medical bills and types of treatment that are most important to you, at a price that suits your budget.

To help you understand and fully benefit from Health Choices for Me, we have tried to keep the plan itself, the choices you have to make and this document simple and transparent. As a result, there shouldn't be any nasty surprises when you come to claim.

My Cover

Health Choices for Me has been designed to give you the control to build a private medical insurance policy that's right for you, but not overload you with too many options or confusing limits.

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

Essential Cover

Every Health Choices for Me plan starts with Essential cover, a standard part of the plan that doesn't change.

We believe in-patient treatment is an essential element of healthcare, as are several others such as MRI/CT scans and out-patient surgery. Providing that your specialist fees are within those detailed on our fee schedule, there are no limits to the amount we will pay on the treatment detailed over the page, allowing you to concentrate on getting better and back to health.

Some people believe the NHS offers good treatment of cancer once it has been diagnosed, so we have excluded treatment for diagnosed cancers from Essential cover in order to keep costs down. Cover for cancer is available as an optional extra as explained in the 'Personalise your cover' section.

Once you have read about Essential cover turn the page to personalise your plan.

Please remember the information in this table should be read alongside the other sections of this document, particularly "My Exclusions" and "My Claim".

Cover module

How much cover?	What does this include?
Unlimited	**In-patient and day-patient treatment** Consultant & specialist fees, diagnostic tests as an in-patient or day-patient, pre-admission tests and hospital charges (including any necessary medical aids e.g. knee braces) at any hospital on the Hospital List. **CT, MRI & PET scans** At any hospital on the Hospital List. Includes professional fees where appropriate. **Out-patient surgery** Surgical procedures performed by a specialist at any hospital on the Hospital List. **Post-operative physiotherapy** Up to 3 sessions of post-operative physiotherapy as an out-patient following in-patient or day-patient surgery. **Private ambulance** Medically essential travel to, between or from hospital in a private road ambulance in connection with in-patient or day-patient treatment. **Home nursing** Home nursing following authorised in-patient and day-patient treatment. **Parental accommodation** You can stay in hospital with your child (up to the age of 18) if they are having treatment under the policy. **GP helpline** Talk to a GP, 24 hours a day, 7 days a week if you need any help or advice on a medical problem. **£250 per night NHS cash benefit** Paid if you have free in-patient treatment under the NHS that would be covered under your policy. **£250 Hospice donation** We make a donation to your hospice if you are admitted for care. ***With the exception of the £250 hospice donation, no benefit will be paid for diagnosed cancer conditions as these are included in the optional Cancer Cover module on page 10.***

Personalise Your Cover

The next stage in building your Health Choices for Me plan is to select what else you would like to be covered for in 3 steps. Here you can personalise your plan by choosing limits within each of the modules of cover, from unlimited to no cover, giving you more control over your monthly premiums.

Details of what is covered under each module are listed over the page to let you make an informed decision on what is most important to you. To find out exactly what these terms mean, see the “My Definitions” on page 2.

Cover modules

How much cover?

Your choices	What does this include?
Unlimited Up To £1000 Per Year Up To £500 Per Year No Cover	Consultant and specialist fees and diagnostic tests such as X-rays, ECGs and pathological tests. Please note that CT, MRI and PET scans are included as standard under Essential Cover. ***No benefit for diagnosed cancer conditions as these are included in the optional Cancer Cover module below.***
Unlimited No Cover	Extends the scope of benefits under Essential Cover (such as surgery and scans) to include treatment for diagnosed cancer and adds unlimited benefit for oncology and specialist consultations for cancer. ***For more details go to the My Cancer Cover section on page 14.***
Unlimited Up To £300 Per Year No Cover	Costs for physiotherapy, osteopathy, podiatry and chiropractic treatment received as an out-patient.
No Excess £100 £250	**Add an excess if you'd like to bring your premiums down further.** If you choose to add an excess to your policy it will apply per person, per year to total claims across all cover modules, not per module. If you make multiple claims in one policy year, the excess will only be deducted once per person.

Will your treatment charges be paid in full?

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

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

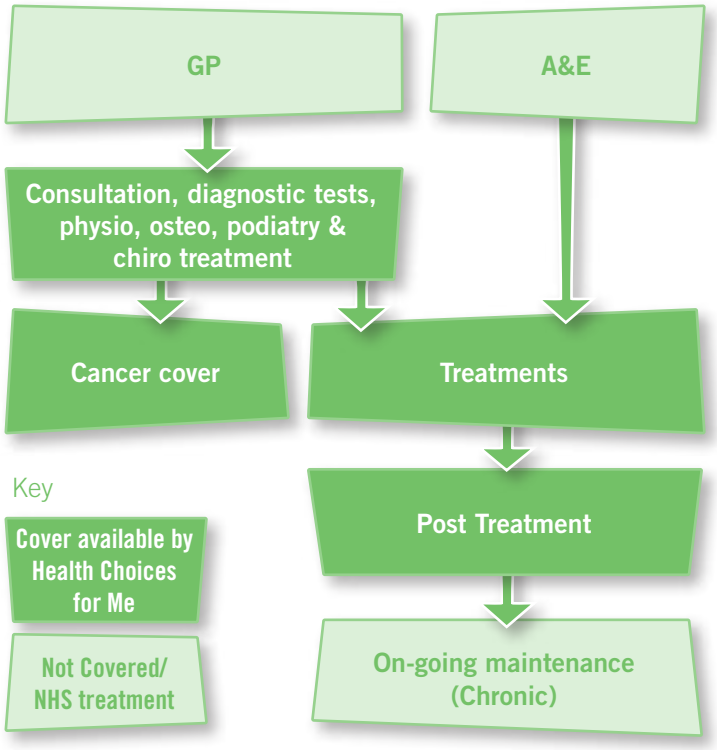
Secondly, we also have to ensure that the fee a specialist charges for any claim you make is within the limits we will pay. We publish a fee schedule, which sets out the maximum fees we will pay specialists for the treatment they provide to you. It is therefore important that you follow our claims process detailed on page 36.

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

To see our most up-to-date fee schedule, please visit our website or contact our Service Centre on 0300 123 3200.

How does My Cover work in practice?

Ok, so we've detailed what is covered, but what does this mean in practice? What would you do if you had to go and get treatment for a condition? What would we cover? The diagram provides an 'at a glance' summary but please remember that you must contact us first so that we can authorise the consultation and any tests or treatment that you need.



GP Helpline - 0800 331 7933

With Health Choices for Me, you have access to a confidential GP helpline, 24 hours a day, 7 days a week. This valuable service allows you to get information and advice about a health concern you may have or even concerning a member of your family or a diagnosis that you have already received.

All you do is make an initial telephone call to the GP Helpline number 0800 331 7933 and an experienced operator will arrange for a UK based GP to call you back at a time convenient to you, whether it is day or night.

With no limit to the length of the call, you may even find that you don't need to visit your GP or Accident & Emergency, saving you time and worry.

National Institute for Health and Clinical Excellence (NICE) guidelines - our approach and the impact on your cover

NICE is an internationally renowned, government funded body that is responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

We use NICE approval as the main benchmark for experimental and/or unproven therapies and drugs. NICE have two measures of approval; clinical effectiveness and cost effectiveness. Some treatments get clinical approval but not cost effectiveness approval, i.e. they work but are too expensive for the NHS.

It is important to explain how we use NICE guidelines and the impact our approach has on what is and isn't covered by Health Choices for Me.

Our approach is simple:

- We ignore any decision by NICE relating to cost effectiveness
- Treatments that have been approved by NICE for clinical effectiveness, are covered by Health Choices for Me
- Treatments that have not been approved for clinical effectiveness are not covered by Health Choices for Me.

Explaining your cover for drug treatment

Any drug that is approved by NICE for clinical effectiveness is covered by Health Choices for Me, regardless of any decision on cost effectiveness.

My Cancer Cover

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

As a result, with Health Choices for Me you have the choice of whether to include cancer cover or not in your plan, again helping you to build a policy that's right for you, your family and your budget.

If you choose no cancer cover:

Any initial consultations and tests leading to the diagnosis would be covered under the Out-Patient module (if selected) or the Essential module in the case of scans or in/day-patient procedures. However, once a cancer condition has been diagnosed, you are not covered for any treatment, monitoring or any further diagnosis related to the cancer under your Health Choices for Me policy. Instead, you will need to be referred to the NHS for treatment.

If you choose unlimited cancer cover:

Health Choices for Me offers you cover for all stages of cancer:

- Diagnosis
- Treatment that is aimed at affecting the growth of the cancer
- Maintaining and monitoring the cancer when in remission
- Palliative care (this is aimed at controlling the symptoms of cancer)
- Terminal care (when the focus is to improve the quality of life, not to cure or control the cancer and usually if the patient is approaching the end of their life).

This table will help to explain what is and isn't covered:

Treatment	What does this include?	
Place of treatment	We cover treatment in hospitals and at home if you need to have chemotherapy	✓
Diagnostic	We cover all consultations, tests & scans.	✓
Surgery	We cover surgery including the removal of a tumour and consequent reconstructive surgery that you need.	✓
Preventative	Preventative screening, treatment or vaccines are not covered by Health Choices for Me.	✗
Drug therapy	We cover all types of drug therapy for your cancer, including chemotherapy & drugs to maintain any remission, providing they have received NICE approval for clinical effectiveness.	✓
Radiotherapy	We cover radiotherapy including when it is given for pain relief.	✓
Palliative	We cover palliative treatment of cancer.	✓
End of life care	We cover treatment of terminal cancer.	✓
Monitoring	We cover follow up reviews related to the continuing care of your cancer.	✓
Limits	We do not place a time or financial limit on your cancer cover.	✓
Other benefits		
NICE appraisal	We use NICE as our main benchmark & cover drugs and treatments that have been approved as being 'clinically effective', even if NICE have rejected them on 'cost-effectiveness' grounds. Please refer to page 13 for details about NICE.	✓
Clinical trials participation	We are very supportive of clinical trials, and your policy remains fully valid throughout the trial. However, the experimental treatment and any complications arising from it remain the responsibility of the research team and are not covered under your policy.	✓

Examples of how My Cancer Cover works in practice

The following are examples of how cancer cover works in practice. Examples 1 and 2 below only apply if you choose the Unlimited Cancer Cover option, and example 3 shows how treatment could work in practice if this option wasn't chosen.

It is important to note that you will be eligible for treatment at a hospital on the current Hospital List and we will pay for treatment charges in full if specialist fees are within those detailed on our fee schedule. To see our most up-to-date fee schedule, please visit our website or contact our Service Centre on 0300 123 3200.

Example 1

Beverley has been with Exeter Family Friendly 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?

We don't class cancer as a chronic condition, so providing Beverley has pre-authorised the claim with us, we will pay for the consultations, operations and breast reconstruction. Crucially, we will pay for all radiotherapy, chemotherapy and hormone therapy that are needed to treat the cancer on an ongoing basis.

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

Her specialist:

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

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

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

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

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

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

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

Her specialist has recommended a treatment plan:

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

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

We do not consider cancer to be a chronic condition. The whole of the treatment plan is eligible.

Example 2
David has been with Exeter Family Friendly 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?

We do not consider cancer to be a chronic condition. As this is a new condition, the chemotherapy and stem cell transplant will be paid for provided that the procedure is not experimental, see "My Exclusions" on page 17.

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

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

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

Example 3
Jenny has been diagnosed with cancer and did not choose the Unlimited Cancer Cover option.

What will her policy cover?

Any initial consultations and tests leading to Jenny's diagnosis would have been covered under the Out-Patient module (if selected) or the Essential module in the case of scans or in/day-patient procedures. However, once cancer has been diagnosed, she will not be covered for any treatment, monitoring or any further diagnosis related to the cancer. Instead, she will need to be referred to the NHS for treatment.

Example 4
Eric would like to be admitted to a hospice for care aimed solely at relieving symptoms.

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

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

My Exclusions

We have tried to keep our policy exclusions as simple as possible and we hope this section provides you with the reassurance that you need. Remember that what you are and what you are not covered for will also depend on the cover you select and the choices you make.

Please ensure that you are happy that the exclusions in this section are acceptable to you. Only buy Health Choices for Me if you are happy that the cover we provide meets your needs.

If you are worried or wish to clarify anything about the exclusions in Health Choices for Me, please contact us or your own financial adviser.

What isn't covered by Health Choices for Me?

Pre-existing conditions ✖

Pre-existing conditions may be excluded from your cover. Please refer to the "My Application" section for more information.

Treatment by your GP, optician or dentist ✖

This includes consultations, tests, check ups or prescriptions:
- Provided by your GP, optician or dentist,
- Provided in your GP surgery, or;
- Provided by a consultant when ordinarily provided by your GP.

Sight, hearing or dental disorders ✖

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

Emergency treatment ✖

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

Out-patient drugs & dressings ✖

Drugs & dressings resulting from out-patient treatment are not covered. However, we do cover those prescribed immediately following an in-patient/day-patient stay in hospital or out-patient surgery.

Please note that this exclusion does not apply to cancer drugs if you choose the unlimited cancer cover option. Please refer to My Cancer Cover on page 14.

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 20.

However, please note that this exclusion doesn't apply to cancer treatment if you choose the unlimited cancer cover option. Please refer to My Cancer Cover on page 14.

Renal dialysis ✖

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

Major organ transplants ✖

These include:
- Investigations done before a major organ transplant operation, or treatment needed as a result of a major general transplant operation.

However, we do cover corneal and skin grafts. If you choose the unlimited cancer cover option, we also cover transplants related to cancer, such as bone marrow and stem cell transplants, provided they are not experimental. Please refer to My Cancer Cover on page 14.

Mental & psychological treatment ✖

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

Treatment overseas ✖

Treatment outside the UK is excluded.

Treatments in nursing homes ✖

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

However, please note that this exclusion does not apply to cancer treatment if you choose the unlimited cancer cover option. See My Cancer Cover on page 14.

Convalescence & rehabilitation ✖

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

Preventative screening procedures, treatment & tests ✖

These include:
- Screening procedures as a result of poor personal or family history
- Cervical smears, mammograms, preventative cancer screening, osteoporosis screenings etc
- Well person health checks and screenings
- Vaccinations, immunisations.

Self-elected treatments ✖

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

Cosmetic or plastic surgery ✖

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

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

Pregnancy & fertility ✖

We do not consider pregnancy or childbirth to be illnesses and therefore you are not covered for treatment or investigations in connection with:
- Pregnancy or childbirth
- Abortion
- Any form of assisted reproduction such as in vitro fertilisation
- Infertility.

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

Complementary treatments ✖

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

However, we do cover physiotherapy, osteopathy, podiatry and chiropractic treatments if you choose the manipulative treatment cover option.

Professional sports injuries ✖

Treatment required as a result of an injury sustained whilst training for or participating in sport for which you receive payment or sponsorship (other than travel costs).

Experimental treatment ✖

If any treatment or drug therapy is not clinically approved by NICE, it is not covered by Health Choices for Me. Please refer to page 13 for more details.

If you are worried or wish to clarify anything about the exclusions in Health Choices for Me, please contact us or your own financial adviser.

Your cover for chronic conditions

The following section explains about chronic conditions and how they work in practice.

What is a chronic condition?

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

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

Please note that we do not consider cancer to be a chronic condition. Please refer to My Cancer Cover on page 14.

What does this mean in practice?

If we believe that the condition for which you need treatment is chronic, we will pay for the initial investigations leading to a diagnosis and the treatment needed to stabilise the condition. We will not pay for treatment once the diagnosis has been made and the condition has been stabilised.

What if your condition gets worse?

If your condition gets worse, in some cases we will pay for further treatment. We may pay the costs of an acute episode of a chronic condition. For example, we consider asthma to be a chronic condition and do not pay for any ongoing treatment or monitoring. However, an asthma attack would be classed as an acute episode. If you need treatment to stabilise the condition we would pay the costs. We would usually request a medical report or ask for additional information.

Examples of how this works

These examples refer to applicants who have chosen the Full Medical Underwriting option. It is important to note that you will be eligible for treatment at a hospital on the current Hospital List and we will pay for treatment charges in full if specialist fees are within those detailed on our fee schedule. To see our most up-to-date fee schedule, please visit our website or contact our Service Centre on 0300 123 3200.

Example 1 – Angina & Heart disease

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

We don't class angina as a chronic condition, so as long as Alan has received authorisation from us and the investigations are covered under the benefit limits of the plan we will pay the costs for these investigations. We will not, however, pay for the medication.

Two years later, Alan's chest pain recurs more severely and his specialist recommends that he have a heart by-pass operation.

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

Example 2 – Asthma

Eve has been with Exeter Family Friendly for five years when she develops breathing difficulties and her GP refers her to a specialist who arranges for a number of tests. These reveal that Eve has asthma. Her specialist puts her on medication and recommends a follow-up consultation in three months, to see if her condition has improved. At that consultation Eve states that her breathing has been much better, so the specialist suggests she have check-ups every four months.

We will pay the cost of the initial consultation and tests, provided that Eve has received authorisation from us and benefits are available under the terms of the plan. We will not, however, pay for the medication.
Once the condition has stabilised, we will not pay for the check-ups.

Eighteen months later, Eve has a bad asthma attack.

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

Example 3 – Diabetes

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

We class diabetes as a chronic condition. However, if Deidre has received authorisation from us and has the necessary cover options in the plan we will pay the costs for the initial consultation and any investigations, followed by the costs for any follow up consultations, but only until the condition has been stabilised. We will not, however, pay for the medication.

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

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

Example 4 – Hip Pain

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

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

My Costs

We know that everyone has a different budget to work to and different needs from their private medical insurance. Health Choices for Me reflects this and gives you the control to build a policy that's right for you.

This section explains how you can lower your premiums by benefiting from one of our discounts including those that recognise and reward good health. It also explains how you pay your premiums and how they will increase over time.

We believe that you deserve a simple plan that is easy to understand and, importantly, that is designed to be used should you need to. Health Choices for Me does this.

My costs

Modules

Health Choices for Me is a modular private medical insurance plan, which means that you build your cover by making choices to suit both what you need from your policy and your budget.

Each Health Choices for Me policy starts with an "Essential" module; this forms the basis of your cover (to find out what is covered by each of the cover modules, please see the "My Cover" section).

Starting with your Essential module, you have to choose the level of cover you want to have within three further modules. In each case, the less cover you select, the lower your premiums will become.

Choice 1) Out-patient treatment

You choose between the following options:

- Unlimited cover
- Up to £1,000 per year
- Up to £500 per year
- No cover.

Choice 2) Cancer cover

You choose between the following options:

- Unlimited cover
- No cover.

Choice 3) Manipulative treatment

You choose between the following options:

- Unlimited cover
- Up to £300 per year
- No cover.

Excesses

In addition to the choices you make about your cover which affects your premiums, with Health Choices for Me you have the option to choose from a range of excesses to save you money each month.

If you choose an excess, it means that any benefits we would otherwise have paid under the policy will be reduced by the amount of the excess. The higher the excess, the lower your premiums will be.

You can only choose one excess per policy. This excess then applies individually to each person to be covered by your policy in each policy year. If there are multiple claims or conditions for one person within one policy year, then the excess is only deducted once.

Your options are:

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 person covered by your policy each year
£250	You have to pay the first £250 of eligible treatment costs for each person covered by your policy each year

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

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

If you incur costs that are not eligible under your policy because you have not selected the relevant cover module, or the costs exceed a benefit limit under the module, those costs will not count towards your excess.

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

How does an excess work in practice?

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

During June 2010, 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.

eg

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

During late May, Becky injures herself playing badminton and is immediately referred by her GP to a specialist. She sees the specialist on 28th May and the bill for this is £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.

Janet has a Health Choices for Me policy which covers herself and her husband Fred. They chose a £250 excess and the policy year starts on 1st January 2010. Their policy includes unlimited out-patient and cancer cover but no cover for manipulative treatment.

Janet makes a claim in April 2010 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, her husband Fred is referred by his GP to a physiotherapist for a ligament problem. His treatment costs come to a total of £200, however as Fred is not covered for manipulative treatment, we will not pay anything towards this treatment and these costs will not count towards the £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 plan, so he will pay the first £250 and we pay the balance of £1,750.

Mary has Health Choices for Me with an excess of £250. Mary chose to cover herself for up to £300 per year manipulative treatment.

In January, Mary injures her back and is referred to an osteopath. She has ten sessions of osteopathy at a cost of £40 per session, and sends the invoices to us. Initially, we apply the benefit limits of her plan, £300 per year for manipulative treatment. This means that only £300 of the £400 treatment costs are eligible for benefit.

However, as Mary also has an excess of £250 on her policy, we will then deduct this from the £300 allowable, so we will only be liable for £50 of the costs. Mary will therefore need to pay £350 of the costs herself.

The following shows what would have been payable had no excess been chosen, together with the amount payable with the excess.

	No Excess	**£250 Excess**
	£	£
Total of Invoices	400	400
Benefit available	300	300
Excess deductible	0	250
Amount payable by us	300	50
Amount payable by Mary	100	350

Health discounts

There are a number of ways in which you can reduce the amount you pay each month.

Body Mass Index (BMI)

BMI is a number calculated from a person's height-to-weight ratio. If your BMI is over 18 and under 25, you will benefit from a 10% reduction in your premiums.

Recommended BMI chart	
Underweight	BMI 18.0 or less
Ideal	BMI 18.1 – 24.9
Overweight	BMI 25-30
Obese	BMI 30-40
Very obese	BMI greater than 40

Weight	lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
Height	kgs	45.4	47.6	49.9	52.2	54.4	56.7	59.0	61.2	63.5	65.8	68.0	70.3	72.6	74.8	77.1	79.4	81.6	83.9	86.2	88.5	90.7	93.0	95.3	97.5
feet	cm																								
5'0"	152.4						24.4	25.4																	
5'1"	154.9							24.6	25.5																
5'2"	157.5	18.3							24.7	25.6															
5'3"	160.0	17.7	18.6							24.8	25.7														
5'4"	162.6		18.0	18.9							24.9	25.7													
5'5"	165.1		17.5	18.3							24.1	25.0													
5'6"	167.6			17.8	18.6							24.2	25.0												
5'7"	170.2				18.0	18.8							24.3	25.1											
5'8"	172.7				17.5	18.2							24.3	25.1											
5'9"	175.3					17.7	18.5							24.4	25.1										
5'10"	177.8						17.9	18.7							24.4	25.1									
5'11"	180.3						17.4	18.1								24.4	25.1								
6'0"	182.9							17.6	18.3								24.4	25.1							
6'1"	185.4								17.8	18.5								24.4	25.1						
6'2"	188.0									18.0	18.6								24.4	25.0					
6'3"	190.5									17.5	18.1									24.4	25.0				
6'4"	193.0										17.6	18.3									24.3	25.0	25.6		
6'5"	195.6											17.8	18.4									24.3	24.9	25.5	
6'6"	198.1												17.9	18.5											24.8

Non-smoking

If you are a non-smoker your premiums will be reduced by 10%.

The following example shows how you can benefit from these available discounts with Health Choices for Me. Please note that these discounts apply to adult premiums only:

Starting Cost		£80 per month
BMI discount	10%	
No smoking discount	10%	
Total Discount	20%	£16 per month
Net cost		£64 per month

Reimbursing me

It is normal for us to pay for your treatment direct to the hospital or specialist. However, if you pay for this treatment yourself (and we have authorised the treatment), we will reimburse you by transferring the money due to you directly into the bank account used for your premium payments. You must send receipted invoices to us within 3 months of the date of treatment.

Paying your premiums

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

If you do not pay your premiums for up to three months you will need to pay any premiums you missed.

If you do not pay your premiums for between three and six months, you will need to pay any premiums that you missed and we will also require evidence of your health before your cover can start again.

If you do not pay your premiums for six months or longer, 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.

Renewing Health Choices for Me

Health Choices for Me is an annual policy so every year we will advise you of any changes to your policy including the premium for the coming year. In addition, you need to advise us of any changes to your personal circumstances (such as address) and any changes which may have an impact on your eligibility for health discounts.

We aim to send the renewal pack to you up to four weeks before your renewal date. You have the option each year of changing or cancelling your policy which you can do by ringing our Service Centre on 0300 123 3200.

Your premiums

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

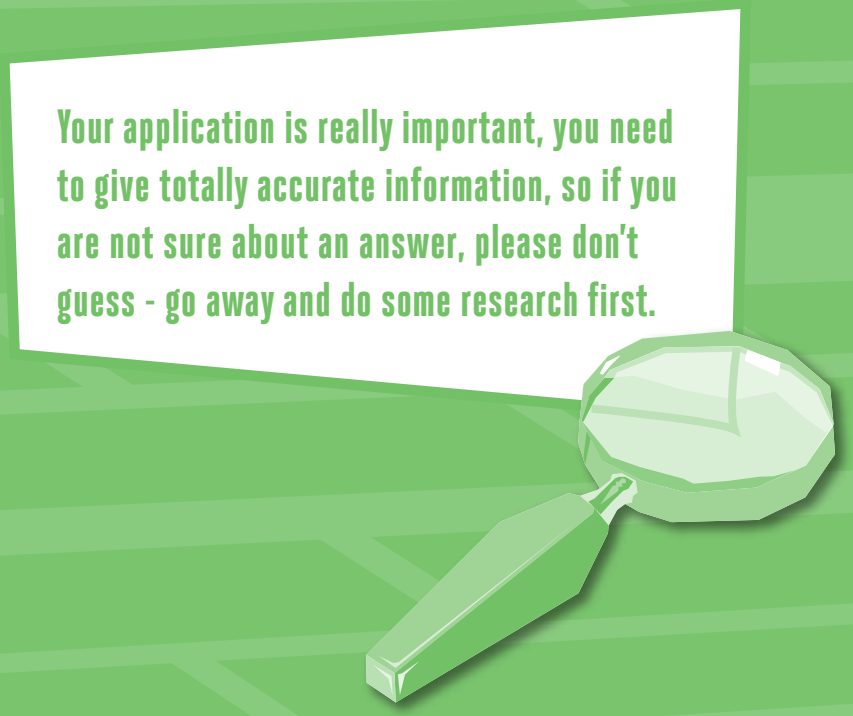
In addition, Health Choices for Me is priced according to age, reflecting the fact that people are more likely to claim as they get older and their treatment is likely to cost more, so you will normally see an age-related premium increase each year.

My Application

We have worked hard to make the application process for Health Choices for Me as straightforward as possible. This section describes how you can apply for Health Choices for Me and how we assess your application.

If you need an explanation of the plan details, please contact your financial adviser.

Guidance can also be obtained from the Money Advice Service website at www.moneyadviceservice.org.uk.



My Application

When you apply you must be aware that it is important for you to provide truthful and accurate information, and answer all questions throughout your application to the best of your knowledge. If you do not, we may not pay a future claim and may also cancel your policy.

As shown in "My Exclusions", the policy is not designed to cover the cost of all treatments. For example, conditions which are on-going or long term may not be covered, our exclusions are listed on pages 18 and 19.

This policy is designed to work alongside, not replace all services provided by NHS. In all cases you are free to use the NHS.

Your application choices

Private medical insurance is designed to cover new medical conditions that begin after the start of a policy. If you need any medical treatment that you could have foreseen before your policy started, this won't be covered by Health Choices for Me.

However, we offer a range of underwriting options which may allow you to increase the scope of your cover to include treatment for conditions which have occurred before your policy started.

We recommend you read through the following underwriting options with your own financial adviser; and discuss what is right for you. For more information and examples of your application choices, please see the policy summary.

Underwriting is the process by which we decide on what terms we will accept a person for cover based on the information they supply.
You have a choice between four ways of applying for cover.

Important notes:

- You must be a resident in the UK to apply
- Please note that once submitted, applications are valid for 6 months
- We underwrite you at application stage, not every year when your policy is renewed.

1) Full medical underwriting

To be eligible for full medical underwriting you must be between the ages of 18 and 79. If you choose this option, you will need to complete a full medical declaration, including details of the medical history of all family applicants. We will then assess the declaration and decide the terms on which we can offer you cover.

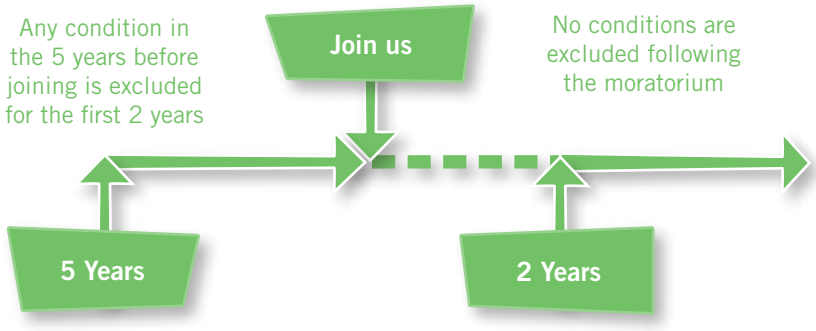
For more details see "What's next - full medical underwriting".

2) Fixed moratorium

Firstly, there are a few rules about who can choose this option:

- All applicants must be 65 years or younger
- All applicants must never have suffered from a heart condition, stroke, cancer, or had a joint replacement or joint resurfacing.
- All adult applicants must never have been diagnosed with diabetes.

Unlike most insurers, we offer a fixed length moratorium. Under this option, pre-existing conditions from the 5 years before joining Health Choices for Me are excluded from cover for the first 2 years of the policy. After this 2 year period is complete, those conditions are then covered subject to the terms of your policy, even if they have recurred during that period. See the diagram over the page.



3) Continued Personal Medical Exclusions (CPME)

Firstly, there are a few rules about who can choose this option:

- All applicants must be 70 years or younger
- All applicants must never have suffered from a heart condition, stroke, cancer, or had a joint replacement or joint resurfacing
- All adult applicants must never have been diagnosed with diabetes
- All applicants must be covered by a current policy which has been underwritten based on a full medical declaration.

This option is designed to allow you the opportunity to carry across the personal medical exclusions from your existing policy. You will need to provide a certificate from your previous insurer with your application. You will also need to answer a few questions about recent or planned medical conditions or treatment.

4) Continued moratorium

Again, there are a few rules about who can choose this option:

- All applicants must be 70 years or younger
- All applicants must never have suffered from a heart condition, stroke, cancer, or had a joint replacement or joint resurfacing
- All adult applicants must never have been diagnosed with diabetes
- All applicants must be covered by a current policy which has been underwritten on a moratorium basis.

This option is designed to let you continue the moratorium period that applies to your existing private medical insurance policy with another provider. You will need to provide a certificate from your previous insurer with your application. You will also need to answer a few questions about recent or planned medical conditions or treatment.

In line with most other insurers, our continued moratorium works on a 2 year rolling basis. This means that any pre-existing condition you had in the 5 years before taking out your current policy is excluded, until you have been free from the condition for 2 years after taking out your current policy. So if, for example, you had a recurrence of a condition within the first 2 years of taking out your current policy, you would have to wait another 2 years without further recurrence before it would be covered.

If you have had your current policy for more than 2 years and have not had a recurrence during that time, we will cover that condition immediately subject to the terms of your policy.

What's next?

Full medical underwriting

We will review your application form and use the information that you have provided to decide the terms of cover that we can offer you. If necessary, we may ask you to get further information from your Medical Practitioner so that we can do this.

No Personal Exclusions

If we are happy with the medical information that you have provided we will offer you Health Choices for Me on standard terms. This means without any personal exclusions.

Personal Exclusions

If the medical information that you have provided with your application has highlighted any pre-existing conditions that we feel will need treatment in the future, we may offer you Health Choices for Me with special terms. This will mean that some pre-existing conditions are excluded from cover. These will be shown on your Policy Certificate.

Decline

Unfortunately in some cases we have to decline an application as a result of medical information that has been provided. We will advise you of this in writing.

Fixed moratorium

Providing you are eligible for this option your policy will start on acceptance of your application or at a date you specify on the application, which can be up to one month in advance. We will then issue you with a policy pack, which will include a certificate detailing the date your moratorium is effective from.

Continued Personal Medical Exclusions and Continued Moratorium

Providing we accept your application for one of these options, your policy will start on the date you specify on the application, which can be up to one month in advance. You should ensure that there is no break in your cover, so you should normally choose your start date to be no later than when your current policy ends.

We strongly recommend that you do not cancel your existing policy until we confirm that we have accepted your application and you are happy with the terms we offer.

Continued Personal Medical Exclusions

We will then issue you with a policy pack, which will include a certificate detailing your personal medical exclusions. We reserve the right to add exclusions or decline the application.

Continued Moratorium

We will then issue you with a policy pack, which will include a certificate detailing the date your moratorium is effective from.

Can I change my mind?

If you are not happy with the terms that we offer, you can cancel your policy within 30 days of receiving the Welcome Pack or within 30 days after the policy starts, if later. We will refund any premium that you have paid if no claims have been made.

My Options

Having joined Health Choices for Me, there are a number of options available to you to make sure your policy always meets your needs.

If you need to update your details, review your cover or make any other changes, let this section be your guide.

My Options

We have designed Health Choices for Me to be flexible to your changing needs. This section explains what to do if your circumstances change and the options available to you to make changes to your policy.

Renewing Health Choices for Me

As described in the My Costs section, Health Choices for Me is an annual policy so every year we will advise you of any changes to your policy including the premium for the coming year.

We will always give you plenty of notice and we aim to send the renewal pack to you up to four weeks before your renewal date. Each year we will ask you whether you can benefit from a reduction in your premium if your BMI is above 18 and below 25 or you haven't smoked for 12 months. Please note that we may not be able to pay a future claim if you apply for these discounts when they are not due to you.

Each year, you have the option of changing or cancelling your policy which you can do by ringing our Service Centre on 0300 123 3200.

Making changes to your policy

If any of your details change, please let us know. We will always send information to the address that you supplied on your application form unless you tell us of a change of details.

Some things can only be changed at your renewal; for example, a change in the policy excess. If you want to discuss any aspect of your policy, please ring our Service Centre on 0300 123 3200 who will be able to help you.

Adding a dependant to the policy

Once your child is over 3 months old you may add them to your policy. Children under 5 years are covered for free and they may remain on your policy until the renewal after their 21st birthday, or their 25th birthday if they are in full time education. Simply contact our Service Centre on 0300 123 3200 who will be able to help you.

Cancelling your policy

We don't want you to leave us but understand that sometimes circumstances change and you may wish to cancel your policy.

You can cancel your policy up to 30 days after you receive your policy documents or within 30 days of when the policy starts, if later. If you need to cancel your policy, please contact our Service Centre on 0300 123 3200, send an email to member@exeterfamily.co.uk or write to us, using the address on the back page of this document.

My 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.

This section explains how the Health Choices for Me claims process works. We have provided a step by step process to help guide you through what you need to do.

My Claim

The claims process

Approved treatment requires a referral from your GP and results in you seeing a consultant or specialist.

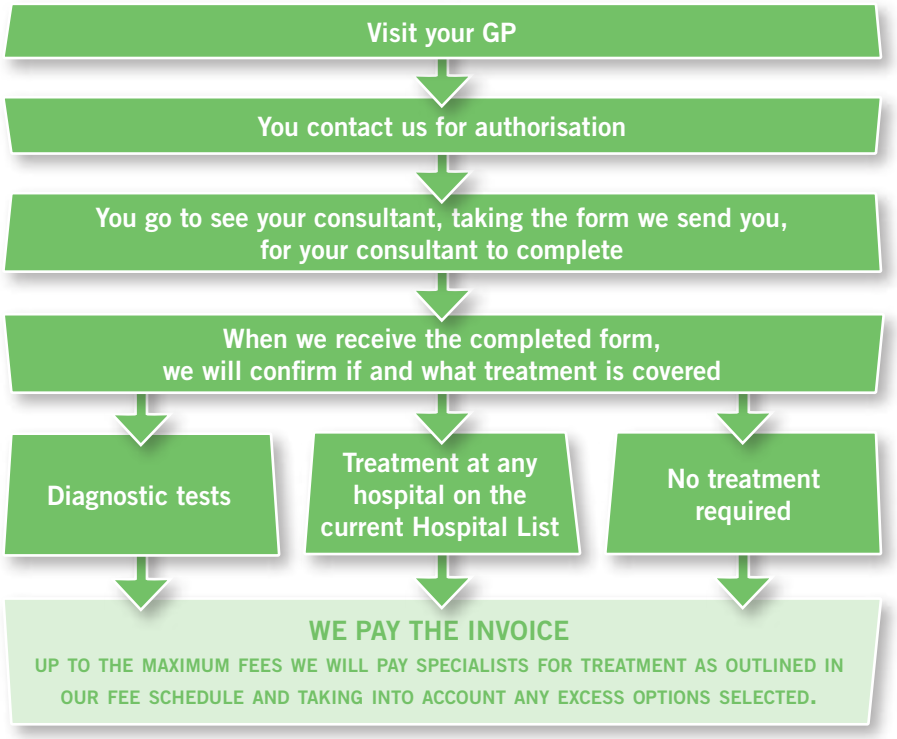
Before seeing your consultant, please contact our Service Centre and they will send you a form, which you will need to give to your consultant to complete. On this form, the consultant will tell us what treatment is needed (if any) and their fees, and we will then contact you to let you know whether this is covered. If covered, you can then proceed to benefit from any treatment or diagnostic tests that are recommended.

So how does it work in practice?

Claims – important notes

- Claims must be authorised by us before you go ahead with any consultations, tests or treatment. This can be done by calling our Service Centre on 0300 123 3200. Treatment will only be eligible at a hospital on the current Hospital List; if you do not contact us for authorisation your claim may not be paid
- Emergency treatment is not covered. Once your condition has been stabilised and if your consultant agrees, you can be transferred (with our prior approval) to private facilities or become a private patient within the NHS. Please call our Service Centre on 0300 123 3200 to authorise your claim
- Claims will not be paid if your premiums are not up to date
- Additional information may be required from your GP at the time of claim
- We must receive all outstanding invoices within 3 months of the date of treatment. If we receive the invoices after 3 months, they will not be paid
- If a claim can be paid under another insurance policy or by anyone else, we will only pay our proportionate share
- Claims for NHS Cash Benefit must be received within 3 months of the date of treatment.

The following chart will help to explain.



Cancelling your policy

We never want to cancel your policy, but in the following circumstances we will have to do so:

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

My Insurance Company

Over 80 years of experience has taught us the importance of protecting our customers' health, the reassurance and the crucial support that it can provide when people need it most.

We are an integrated health company that provides a range of complementary protection products for the benefit of our customers and their families, enabling them to minimise the impact and cost of ill-health.

We are a mutual friendly society and we only work for you. Whilst all UK financial organisations are authorised by the Financial Services Authority, mutual organisations are not owned by external shareholders (like a PLC) but work for, and only answer to customers like you.

We believe this is important because:

- On average mutual customers are more likely to recommend a mutual organisation than a PLC
- With no shareholders to pay, whilst a PLC has to pay shareholder dividends from the profits it makes each year, mutual insurers like us can ensure that our profits are reinvested to give you better returns, better value and higher levels of service
- We believe that our staff want to try that bit harder when our customers are members of the organisation they work for.

The rest of this section provides information about how we handle information about you and what you can do if you want to make a complaint.

My Insurance Company

Contacting us

If you are thinking about buying Health Choices for Me, please contact your financial adviser.

If you already have a Health Choices for Me policy, please contact our Service Centre:

Telephone:	0300 123 3200
Email:	member@exeterfamily.co.uk
Opening times:	Monday to Friday 8am – 6pm
or visit our website:	www.exeterfamily.co.uk

Our Chief Executive, Andy Chapman, is interested in hearing your views and opinions. If there is anything in particular that you would like to mention to Andy, please contact him by email at andrew.chapman@exeterfamily.co.uk or in writing using the address at the back of this document.

What we require from you and your rights

You must answer any questions you are asked as fully and as accurately as you can, to the best of your knowledge and belief. If you do not we may refuse to pay your claim and could cancel your policy.

How we handle information about you

Due to the nature of what we do, we hold personal information about you. This means that we can make sure we provide the best quality cover that you expect. You have our assurance that this information will always be treated with confidence.

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

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

- Cooperation with fraud prevention agencies
- Passing information to carefully selected parties (including the intermediary who arranged your cover, if any) as part of our administering your plan
- Passing information to carefully selected parties for research, advertising, marketing or selling purposes (for example to tell you about new products).

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.

We don't always get it right

We aim to provide our members with the service that you expect, but we don't always get it right. If you are not satisfied with any aspect of our service:

Firstly

Contact our Service Centre on 0300 123 3200 who will help you resolve your query. If their response isn't satisfactory, please ask to be referred to a manager to discuss your concerns. This nearly always brings a conclusion that is satisfactory to everyone.

If you remain unhappy

Please contact our Customer Complaints Handler. Your complaint will be acknowledged within 5 working days and we will contact you with an update if it hasn't been resolved in 20 working days.

Email: customercomplaints@exeterfamily.co.uk

Customer Complaints
Exeter Family Friendly
Lakeside House
Emperor Way
Exeter EX1 3FD

Finally

If you are not happy with our response or we do not provide it within 40 working days, you have the option of asking the independent Financial Ombudsman Service to investigate the matter on your behalf. You can visit their website at www.financial-ombudsman.org.uk or you can contact them at:

Tel: 0800 023 4567

The Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London E14 9SR

Language and Law

All documents relating to Health Choices for Me, including any communications with you will be in English. The laws of England and Wales apply to Health Choices for Me.

Financial Services Compensation Scheme (FSCS)

Exeter Family Friendly 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.

Tell us how we are doing

It's always nice to hear if we're doing a good job but equally we need to know if we can improve things. If you have any comments, good or bad, please contact us by writing, emailing or ringing:

Telephone: 0300 123 3200

Email: member@exeterfamily.co.uk

In writing: Exeter Family Friendly
Lakeside House
Emperor Way
Exeter EX1 3FD

Design - www.arena-design.co.uk REF: EFF4656

Exeter Family Friendly, Lakeside House, Emperor Way, Exeter EX1 3FD
Members: T: 0300 123 3200 e: member@exeterfamily.co.uk
Financial Advisers: T: 0300 123 3203 e: adviser@exeterfamily.co.uk
www.exeterfamily.co.uk

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