Freedom
Health Insurance

Elite

Group Member's Guide to Cover

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1. Welcome to Freedom Health Insurance

Welcome to private medical insurance from Freedom Health Insurance.

1.1 About Freedom Health Insurance

Established in 2003, Freedom Health Insurance is an award-winning health insurance provider delivering affordable and innovative medical insurance solutions to individuals and companies.

Based in Poole, Dorset, our friendly and knowledgeable teams aim to give you the highest levels of customer service and we are delighted that you have joined us.

We have tried to keep all our documents as simple as possible to read and understand so you have all the information you need about the cover provided by the group scheme.

We suggest you make a note of your policy number and our contact information and keep these separately.

In the meantime, if you have any questions or queries regarding your cover, do get in touch and we will be pleased to help you.

For more information about Freedom Health Insurance, visit our website at **www.freedomhealthinsurance.co.uk**

Hoosh Mires

Chief Operating Officer
Freedom Health Insurance

Freedom Health Insurance administers all aspects of this group scheme, including membership and claims matters, on behalf of the underwriter. The name of the underwriter can be found on the employee certificate of insurance.

You can check the underwriter's authorisation on the Financial Services Register by visiting the Financial Conduct Authority's website which is **https://register.fca.org.uk** or by contacting the Financial Conduct Authority directly on **0800 111 6768.**

2. How to contact Freedom Health Insurance

Your policy number is shown on the employee certificate of insurance. When you contact us, we will ask for your policy number as it helps us confirm your cover with us.

We are available between 9am and 6pm Monday to Friday (except public holidays). If you call outside these hours, you can leave a message and we will call you back on the next working day.

Making a claim

Phone: **01202 283 580**

Fax: **01202 756 351**

Email: **claims@freedomhealthinsurance.co.uk**

Please call the claims helpline if you want to make a new claim, if you need further treatment, if you have a question about an existing claim or if you want to know whether a specific treatment would be covered.

General enquiries

Phone: **0800 999 2013** or **01202 756 350**

Fax: **01202 756 351**

Email: **info@freedomhealthinsurance.co.uk**

Please call the general enquiries helpline if you have a general question or if you want to make a change such as telling us about a new address.

Calls may be recorded and monitored for training and quality purposes.

Calls to 0800 numbers are free from all consumer landlines and mobile phones. If you are calling from a business phone, you should check with your provider whether there will be a charge for calling an 0800 number.

All written correspondence should be sent to:

Freedom Health Insurance
County Gates House
300 Poole Road
Poole
Dorset
BH12 1AZ

3. About the policy documents

The documents below set out your cover under this policy and must be read together as one document. Please read them carefully so you understand your cover and keep them in a safe place.

3.1 Employee certificate of insurance

The member will receive an employee certificate of insurance at the start of each period of insurance or whenever a change is made to this policy. It is the member's responsibility to check the details on the employee certificate of insurance are correct and to tell us if they are not.

The employee certificate of insurance shows the name of each insured person included under the member's policy. It confirms the benefits provided (as requested by the policyholder), whether pre-existing conditions are covered and any endorsements or excess that applies. The employee certificate of insurance is personal to the member and takes priority over other documents.

When we refer to the employee certificate of insurance in this guide, we use the term 'employee certificate'.

3.2 The Group Member's Guide to Cover (this booklet)

This booklet is the Group Member's Guide to Cover. It summarises the benefits provided and any limits that apply. It tells you what is not covered, how to make a claim and, if you are not happy with the service you receive from us, how to make a complaint.

When we refer to the Group Member's Guide to Cover, we use the term 'guide'.

This guide contains general information about Freedom Elite and shows all the elements of cover that can be provided. You may not have all the cover set out in this guide. It is the employee certificate that shows the specific cover that is provided under this policy. Any elements of cover in this guide that do not appear in the employee certificate are not covered under this policy.

We will not issue a new guide unless we make any material changes to the cover provided by this policy. You can get a replacement copy from our website at www.freedomhealthinsurance.co.uk or by contacting us.

3.3 Cancer cover explained leaflet

This leaflet explains the cover provided for treatment of cancer under this policy. You can get a copy from our website at www.freedomhealthinsurance.co.uk or by contacting us.

3.4 Hospital list

This lists the private hospitals available under this policy and is subject to change from time to time without notice. The hospital cover that applies to each policy will be shown on the employee certificate.

4. About this Group Member's Guide to Cover

We know insurance policies can often be difficult to read and understand. So we have worked hard to make this guide easy to read because we want you to use this policy and take advantage of the cover it provides.

Certain words in this guide are printed in bold type. This is because they are important words that have a specific meaning when used in a particular context. A full list of all these words, with their meanings, is found in chapter 17 (Definitions) starting on page 46 of this guide.

4.1 Rights and responsibilities

An insurance policy is a legal contract between a policyholder and the insurance company and each party has certain rights and responsibilities under that contract.

A contract is arranged and paid for by an employer, on behalf of its employees, between it and the insurance company which provides the cover requested under the contract. So when we refer to the employer, we use the term 'policyholder'. When we refer to the insurance company, we use the term 'underwriter'. When we refer to the contract, we use the term 'group scheme'.

Freedom Health Insurance administers a group scheme on behalf of the underwriter. So when we refer to Freedom Health Insurance, we use the terms 'we', 'us' or 'our'.

A group scheme is arranged by the policyholder for its employees to use. We hold a record of each employee's inclusion in a group scheme which describes the cover provided to the employee by the policy.

When we refer to this record, we use the term 'policy'. A policy is not a legal contract between the employee and the underwriter, but it does give the employee certain rights and responsibilities.

When we refer to the employee, we use the term 'member'.

This guide explains how to use the cover provided by a policy. Each person named on the employee certificate can make a claim or a complaint in their own name even though they are not the policyholder.

When we refer to a person who is named on the employee certificate, and can use the cover provided under a policy, we use the term 'insured person'. A member is also an insured person.

When we provide information about how a policy works to any insured person, we use the terms 'you' or 'your'.

5. About private medical insurance

5.1 What is private medical insurance (PMI)?

Private medical insurance is designed to meet the cost of elective, short-term medical **treatment** provided by a **specialist** that you need because you are suffering from an unexpected **acute condition.**

5.2 PMI and the National Health Service (NHS)

PMI is not designed to replace the NHS, but to add to it and complement it. Having PMI does not mean you will never need to use the NHS again and there are some situations where the NHS is the best place to receive treatment – for example, in an emergency situation.

PMI does not do everything that the NHS does and there a few key areas in particular where PMI may not provide cover. These include:

- accident and emergency admissions;
- medical conditions you had before your cover with us started (these are called **'pre-existing conditions'**); and
- long-term management or maintenance of incurable, prolonged or lifelong conditions (these are called **'chronic conditions'**).

5.3 What is a pre-existing condition?

A **pre-existing condition** is a medical condition you had before your cover under this policy started. We will not cover a medical condition, or a **related condition**, you had within the five-year period before your cover with us started unless we have agreed to cover that condition.

For more information on cover for **pre-existing conditions**, see chapter 11 (Pre-existing medical conditions) starting on page 36 of this guide.

5.4 What is an acute condition?

An **acute condition** is a disease, illness or injury that comes on suddenly and without warning, unexpectedly causing pain or discomfort or other outward physical symptoms.

An **acute condition** will tend to respond quickly to a short period of **treatment** leading to a full recovery, restoring you to the same state of health you enjoyed before you suffered from the **acute condition**. There should be no need for prolonged or long-term future **treatment**. PMI is only intended to cover **treatment** of **acute conditions**.

5.5 What is treatment?

Treatment relates to surgical and medical (non-surgical) procedures that are carried out by, or under the care of, a **specialist** in order to:

- diagnose acute symptoms to see what is causing them;
- cure an **acute condition** to stop it coming back; or
- bring symptoms of an **acute condition** under control and to minimise their effect when a full cure is not possible.

PMI generally only pays for **treatment** that is widely available on the NHS because it has been shown to work and is not considered to be experimental or unproven.

5.6 What is a chronic condition?

A **chronic condition** is the opposite of an **acute condition**. It is persistent and long-lasting in its effects and, in most cases, cannot be cured and only kept under control, perhaps by medication or diet or a change of lifestyle. **Chronic conditions** are often life-long and limiting in terms of quality of life.

5.7 Acute flare-ups of a chronic condition

We will pay for short-term **treatment** to resolve an acute flare-up of a **chronic condition**. An acute flare-up means there is a sudden and unexpected deterioration of a **chronic condition** and short-term **treatment** is needed to return you to the state of health you were in before the acute flare-up happened.

We will not pay for treatment given for symptoms caused by the deterioration of a **chronic condition** where the deterioration is known to be a part of the normal progression of the **chronic condition**.

Similarly, we do not pay for treatment given for recurring relapses of a **chronic condition** that can be reasonably anticipated because they are an expected part of the **chronic condition**.

Our leaflet, Chronic Conditions Explained, gives more detailed guidance on how we look at claims for **chronic conditions**. It contains some typical case studies. You can get a copy of the leaflet from our website at www.freedomhealthinsurance.co.uk or by contacting us.

6. How does this policy work?

6.1 What cover do you have?

Freedom Elite has a mandatory 'core cover' included in all group schemes as standard. It also offers a range of optional additional benefit packages.

6.1.1 Core cover

The Freedom Elite core cover is designed to cover costs relating to **inpatient** and **daypatient treatment** and includes the following benefits:

- **specialist** fees;
- hospital fees;
- home nursing;
- private road ambulance; and
- NHS cash benefit.

The core cover also includes **inpatient** and **daypatient treatment** for certain complications of pregnancy, certain oral surgical procedures and MRI, CT and PET scans. It also provides a cash benefit if you choose to have your **daypatient** or **inpatient treatment** through the NHS.

This policy will include the core cover but it will only include the additional benefits shown below if the policyholder has included them as part of this policy and paid the appropriate premium.

6.1.2 Additional benefits

Freedom Elite offers a range of optional additional benefits. These are:

- outpatient treatment;
- alternative therapies;
- mental health care; and
- dental, optical and private GP fees.

If you are covered for any of these additional benefits, they will be shown on the employee certificate. If an additional benefit is not shown on the employee certificate, you do not have that cover even though it is mentioned in this guide.

> **Important note**
>
> For more detailed information about the benefits provided by Freedom Elite, see chapter seven (What does this policy cover?) starting on page 12 of this guide.
>
> You should also read chapter eight (Exclusions – what is not covered by this policy) starting on page 22 of this guide for more detailed information about the things that are not covered by Freedom Elite.

6.2 What we will pay for

Depending on the cover you have, we will pay for:

- a consultation with a **specialist** to discuss your symptoms after you have been referred to that specialist by your **GP**;
- **diagnostic tests** required by the **specialist** to investigate the cause of your symptoms, diagnose the underlying **acute condition** causing your symptoms, and to develop the correct **treatment** plan;
- the treatment plan put in place by the **specialist** to treat your **acute condition**;
- hospital, surgeon and anaesthetist fees if you need surgery to treat an **acute condition**; and
- a follow up consultation with the **specialist** to confirm the **treatment** was successful.

6.3 Cancer cover

The complex nature of **cancer**, and the range of treatments available, means that **cancer** can be difficult to categorise as an **acute condition** or as a **chronic condition**. Therefore, our approach is to pay for **specialist** consultations, **diagnostic tests** and **active cancer treatment** such as surgery, radiotherapy and chemotherapy.

We will also pay for ongoing follow up monitoring by a **specialist** for as long as you are covered by this policy once the **active cancer treatment** is complete.

Our leaflet, Cancer Cover Explained, gives more detail about the cover we provide for **active cancer treatment**. You can get the leaflet from our website at www.freedomhealthinsurance.co.uk or by contacting us.

6.4 In an emergency

In an emergency, you should call for an NHS ambulance or go to the Accident and Emergency department of your local NHS hospital. Private medical insurance is intended to provide cover for planned, elective treatment and so most private hospitals are not set up for emergency treatment. Therefore, this policy does not provide cover for **accident or emergency admissions**.

If you need further **treatment** after your medical condition has been stabilised and the emergency treatment has finished, please call us as we may be able to provide cover for this.

7. What does this policy cover?

Subject to any limits and excesses that apply to this policy, we will pay the reasonable cost of the **treatment** you need to investigate, diagnose and treat an **acute condition** as long as:

- you are named on the employee certificate we have issued to the member for the **period of insurance** in which **treatment** takes place;
- the policyholder has paid all premiums that are due;
- the symptoms you are experiencing do not relate to a **pre-existing condition** or **related condition**;
- you have the correct cover in place with sufficient benefit available;
- you have been referred to a **specialist** by your GP;
- **treatment** is given by, or under the supervision of, that **specialist**;
- **treatment** is given in line with **established clinical practice**;
- **treatment** is carried out in the **United Kingdom**;
- the person or facility providing **treatment** is licensed to do so, is registered with the relevant governing and regulatory body in line with current legal requirements and is recognised by us; and
- no exclusion or **endorsement** applies.

Unless otherwise stated, all benefit limits apply to each insured person for each **period of insurance**.

Important note about receiving treatment in a hospital that is not within your level of cover

You must always go to a hospital that is shown on our hospital list and is within your level of cover in order for eligible hospital fees for all outpatient, inpatient and daypatient treatment to be paid in full. This includes treatment for psychiatric care under benefit 7.4 Mental health care.

If you do not use a hospital within your level of cover, we will only pay 50% of the eligible hospital charges up to any stated maximum benefit limit.

You can get a copy of our most recent hospital list from our website at **www.freedomhealthinsurance.co.uk** or by contacting us.

7.1 Core cover

This policy will include the core cover.

7.1.1 Specialist fees

We will pay, in full, the fee a **specialist** charges for providing **inpatient** and **daypatient treatment** in hospital as long as the fee is charged in line with our schedule of procedures.

We operate a schedule of procedures that classifies each procedure according to its medical complexity and allocates a maximum financial amount that we will pay towards the fee charged by a **specialist** for that procedure. If the fee charged is greater than the amount we will pay, you will be responsible for paying the shortfall directly to the **specialist**.

You should ask for confirmation of each fee that will be charged by the surgeon and the anaesthetist before proceeding with your **treatment** and check whether we will pay these fees in full. If a shortfall is likely, you will need to discuss this with the **specialist** to make sure you agree on the charges and how the shortfall is going to be paid by you.

The amount that we will pay towards a specialist fee for any particular operation may change at any time and without notice. Any changes we make to our schedule of procedures will be effective immediately. A copy of our current Freedom Elite schedule of procedures is available on our website at **www.freedomhealthinsurance.co.uk.**

7.1.2 Hospital fees

We will pay, in full, the fee a hospital charges for providing **inpatient** and **daypatient treatment** as long as you use a hospital shown on our hospital list that is within your level of cover. The fee includes:

- pre-admission tests, such as blood tests, ECG and chest x-ray, carried out in hospital up to 14 days before your **inpatient** or **daypatient treatment** to check you are fit to receive **treatment**;
- accommodation (including meals and nursing care);
- **critical care**;
- operating theatre and drugs;
- **diagnostic tests**;
- physiotherapy;
- internal implanted prosthesis such as a joint replacement; and
- accommodation for a parent accompanying a child aged 18 years or under.

Treatment in a critical care unit

We will only pay for **critical care** where it is given in line with **established clinical practice** as an essential part of the expected post-operative management of **treatment** of an **acute condition**.

We will pay for unexpected **critical care** in a private hospital that is required to treat unforeseen complications when:

- it follows an elective, non-emergency admission for **treatment** of an **acute condition**;
- the **critical care** takes place in a dedicated critical care unit; and
- the **critical care** is given in line with **established clinical practice**.

(See also exclusion 8.12 Critical care.)

7.1.3 Pregnancy complications

We will pay, in full, the fee charged by a **specialist** (see 7.1.1 Specialist fees) and the fee charged by a hospital (see 7.1.2 Hospital fees) for **inpatient** and **daypatient treatment** related to the pregnancy complications listed below.

- Miscarriage, including missed miscarriage (loss of a pregnancy before completion of 24 weeks).
- Still birth (loss of a pregnancy after completion of 24 weeks).
- Ectopic pregnancy (where the foetus grows outside the womb).
- Molar pregnancy, also called a hydatidiform mole (the placenta and foetus do not form properly and a baby does not develop).
- Post-partum haemorrhage (heavy bleeding immediately after childbirth).
- Retained placenta (where part of the placenta or membrane remains in the womb after childbirth).
- Complications following any of the above conditions.

Emergency caesarean sections

Cover for an emergency Caesarean section is available (in line with NHS guidelines) if there is an immediate risk to the health or life of the baby or mother, or if the baby needs to be delivered early.

If you choose to have private care for the birth at your own expense, and an emergency Caesarean section is needed, we will only pay the extra cost that is above the cost of a normal private delivery.

This means you will still have to pay the proportion of the cost equivalent to that of a normal private delivery.

Outpatient treatment

Any related **outpatient treatment** costs will be covered under the outpatient treatment benefit (see 7.2 Outpatient treatment).

7.1.4 Maternity cash benefit

We will pay the member a cash benefit of £150 for each of the member's children born after the **start date** of this policy.

The member must have had this cover for at least 10 months before the child is born.

7.1.5 Dental surgery carried out by an oral specialist

We will pay, in full, the fee charged by a **specialist** (see 7.1.1 Specialist fees) and the fee charged by a hospital (see 7.1.2 Hospital fees) for **inpatient** and **daypatient treatment** related to the oral surgical procedures listed below when they cannot be carried out by a dentist and you are referred to an oral **specialist**.

- Putting a natural tooth back into the jaw bone after it is knocked out or dislodged because of an accidental dental injury.
- Treating a jaw bone cyst.
- An apicectomy to remove the tip of the root of a tooth and treat the surrounding infected tissue.
- Surgical removal of impacted teeth, buried teeth and complicated buried roots as long as this is **treatment** of an **acute condition**.

Outpatient treatment

Any related **outpatient treatment** costs will be covered under the outpatient treatment benefit (see 7.2 Outpatient treatment).

7.1.6 Home nursing

We will pay, in full, and for up to 13 weeks, the fee charged by a nurse for providing **treatment** in your home immediately following **inpatient** or **daypatient treatment** that was covered by this policy.

The home nursing must be recommended, arranged and supervised by the **specialist** who treated you in hospital.

The nurse must be on the register of the Nursing and Midwifery Council (NMC) and hold a valid NMC personal identification number.

We do not pay for non-medical services such as cleaning, preparation of meals, childcare, assistance with mobility or personal care.

7.1.7 Private road ambulance

We will pay, in full, the fee charged for use of a private road ambulance if you need private **inpatient** or **daypatient treatment** and you have to be medically supervised during the journey:

- from your home to hospital;
- from one hospital to another in order to receive **treatment**; or
- from hospital to your home after you have been discharged.

We do not pay for taxi fares or the use of public transport.

7.1.8 NHS cash benefit (elective inpatient treatment only)

We will pay the member a cash benefit of £200 for each night you spend in an NHS hospital to receive elective **inpatient treatment** that would be covered by this policy if you went into a private hospital. All **treatment** costs must be paid by the NHS.

We do not pay NHS cash benefit for time spent in an accident and emergency department before being admitted to a general ward.

7.1.9 NHS cash benefit (elective daypatient treatment only)

We will pay the member a cash benefit of £100 for each day you spend in an NHS hospital to receive elective **daypatient treatment** that would be covered by this policy if you went into a private hospital. All **treatment** costs must be paid by the NHS.

We do not pay NHS cash benefit for time spent in an accident and emergency department before being admitted to a general ward.

7.1.10 MRI, CT and PET scans

We will pay, in full, the fee charged by a hospital or other diagnostic imaging facility approved by us for the following scans when you have been referred by a **specialist**.

- Magnetic Resonance Imaging (MRI scan).
- Computerised Tomography (CT scan).
- Positron Emission Tomography (PET scan).

We do not pay for MRI, CT or PET scans your **GP** has referred you for.

7.2 Outpatient treatment

If this policy includes this cover, it will be shown on the employee certificate.

7.2.1 Diagnostic tests requested by your GP

We will pay, in full, up to £750, the fee charged by a hospital or other diagnostic imaging facility approved by us for **diagnostic tests** that have been requested by your **GP** without being referred to a **specialist** first.

We do not pay for MRI, CT or PET scans your **GP** has referred you for.

7.2.2 Specialist fees including diagnostic tests

We will pay, in full, the fee charged for **outpatient treatment** given by, or under the supervision of, a **specialist** that your **GP** has referred you to for investigations into, and **treatment** of, an **acute condition**.

The fees include:

- consultations with the specialist;
- diagnostic tests;
- minor surgical procedures not needing a stay in hospital; and
- drugs and dressings used during the outpatient treatment.

We will not pay for any repeat diagnostic tests that your GP has already carried out.

7.2.3 Physiotherapy treatment (on GP or specialist referral)

We will pay, in full, the fee charged for **outpatient treatment** given by a physiotherapist when your **GP** or **specialist** has referred you for **treatment** of an **acute condition**.

If your **GP** has referred you directly to the physiotherapist, we will only pay for up to a maximum of six sessions of **treatment** during a single **period of insurance**.

The physiotherapist must be recognised by us and registered according to current statutory requirements in line with the definition below.

Physiotherapist

A medical practitioner who specialises in physiotherapy treatment, who is a member of the Chartered Society of Physiotherapy (CSP) and who is registered with the Health and Care Professions Council (HCPC).

7.3 Alternative therapies

If this policy includes this cover, it will be shown on the employee certificate.

7.3.1 Alternative therapies (on GP or specialist referral)

We will pay, in full, the fees charged for **outpatient treatment** given by the therapists listed below when your **GP** or **specialist** has referred you for **treatment** of an **acute condition**.

If your **GP** has referred you directly to the therapist, we will not pay any more than six sessions of **treatment** during a single **period of insurance** for all the listed practitioners combined.

- Acupuncturist
- Chiropractor
- Homeopath
- Osteopath
- Podiatrist

Each therapist must be recognised by us and registered according to current statutory requirements in line with the definitions below.

Acupuncturist

A medical practitioner who specialises in acupuncture treatment and who is a member of the British Acupuncture Council, the British Medical Acupuncture Society or the Acupuncture Association for Chartered Physiotherapists.

Chiropractor

A medical practitioner who specialises in chiropractic treatment and whose name appears on the register kept by the General Chiropractic Council.

Homeopath

A medical practitioner who specialises in homeopathic treatment and who is a full member of the Faculty of Homeopathy, the Society of Homeopaths or the Alliance of Registered Homeopaths.

Osteopath

A medical practitioner who specialises in osteopathic treatment and whose name appears on the register kept by the General Osteopathic Council.

Podiatrist

A medical practitioner who specialises in diagnosing and treating abnormal conditions of the feet and lower limbs and who is registered with the Health and Care Professions Council (HCPC).

7.4 Mental health care

If this policy includes this cover, it will be shown on the employee certificate.

7.4.1 Mental health care – inpatient, daypatient and outpatient treatment

We will pay, in full, the fee charged by a psychiatric **specialist** and the fee charged by a hospital for **inpatient**, **daypatient** and **outpatient treatment** given by, or under the supervision of, a psychiatric **specialist** that your **GP** has referred you to for investigations into and **treatment** of an acute mental or psychiatric illness.

- We will pay for **inpatient** and **daypatient treatment** for up to 45 days.
- We will pay up to £2,000 for **outpatient treatment**.

We do not pay for treatment of alcohol, solvent or drug abuse, or addictions of any kind, or medical conditions arising from such abuse or addiction.

What is an acute mental or psychiatric illness?

For the purposes of this policy, an acute mental or psychiatric illness is a mental, nervous or eating disorder associated with present distress or substantial impairment of the ability to function in a major life activity such as employment.

The illness must be clinically significant and not an expected response to a particular life event such as bereavement, relationship or academic problems or acculturation.

What is an eating disorder?

For the purpose of this policy, an eating disorder is any psychological disorder such as anorexia nervosa or bulimia that involves insufficient or excessive food intake.

7.5 Dental, optical and private GP costs

If this policy includes this cover, it will be shown on the employee certificate. There is a compulsory £50 excess that applies to this whole section once per insured person per **period of insurance**.

7.5.1 Routine dental costs

We will refund, in full, up to a maximum of £300, the fee a dentist charges for routine dental services to maintain oral hygiene including:

- check-ups, x-rays, scale and polish and hygienist fees; and
- extractions, fillings, crowns, bridges and inlays.

(See also exclusion 8.13 Dental treatment.)

7.5.2 Accidental dental injury

We will refund, in full, up to a maximum of £600, the fees a dentist charges:

- for **treatment** of an **accidental dental injury** that occurred after the **start date** of your cover with us; or
- for the relief of severe acute pain which cannot be controlled by non-prescription medication.

7.5.3 Optical costs

We will refund, in full, up to a maximum of £200, the fee an optician charges for routine eye tests, prescription glasses and contact lenses.

We will only pay for glasses and contact lenses if the optician has said you need a first prescription for glasses or contact lenses or that your existing prescription has changed.

We do not cover laser eye surgery, optical solutions, accessories such as cases and cleaning cloths or monthly disposable contact lens schemes.

(See also exclusion 8.17 Eyesight and vision disorders.)

7.5.4 Private GP costs

We will refund, in full, up to a maximum of £300, the fee a private **GP** charges for consultations, **diagnostic tests** and minor surgery carried out in the **GP's** own surgery.

(See also exclusion 8.20 GP charges and primary care treatment.)

8. Exclusions – what is not covered by this policy

This section of the guide lists the exclusions that apply to all Freedom Elite group schemes. However, this policy may include cover for some of these exclusions depending on the specific cover you have.

For example, treatment of psychiatric and mental illness is excluded unless this policy specifically has that cover included. If it does, it will be shown on the employee certificate.

8.1 Accident or emergency admissions

We do not pay for an **accident or emergency admission** to an NHS or private hospital.

8.2 AIDS and HIV

We do not pay for treatment for, arising from or related to Human Immunodeficiency Virus Infection (HIV) or Acquired Immunodeficiency Syndrome (AIDS).

8.3 Alcohol abuse, substance abuse and addiction

We do not pay for treatment of alcohol, solvent or drug abuse, or addictions of any kind, or medical conditions arising from such abuse or addiction such as hepatitis, cirrhosis, oesophageal varices and psychiatric conditions.

8.4 Allergies

We do not pay for treatment of any allergic condition or disorder, or to make you less sensitive to the things that cause allergic reactions.

8.5 Appliances, physical aids and devices

We do not pay for the cost of supplying, measuring or fitting of:

- surgical or medical equipment such as neck supports and collars, shoe inserts (orthotics), splints and braces;
- mobility aids such as wheelchairs, crutches and walking sticks;
- external prosthesis such as false or artificial limbs; or
- implantable muscle or nerve stimulators, or intracranial devices for neurological conditions.

8.6 Behavioural, developmental, educational and learning problems

We do not pay for treatment, including psychological or educational assessments, related to behavioural problems such as Attention Deficit Hyperactivity Disorder (ADHD) or developmental, educational and learning difficulties such as dyslexia, dyspraxia, autistic spectrum disorder, slow learning, speech and language delay or slow growth.

8.7 Chronic conditions

We do not pay for treatment, including ongoing and regular monitoring, of a **chronic condition**. Ask for a copy of our leaflet, Chronic Conditions Explained, for further information.

8.8 Contraception and birth control

We do not pay for any form of contraception or birth control procedure including vasectomy and sterilisation (and having it reversed), or any consequence of such procedures.

8.9 Complications caused by excluded conditions and treatment

We do not pay for treatment required due to complications caused by a medical condition or treatment that is not covered, or has restricted cover, under this policy. This includes increased treatment costs on an otherwise eligible claim.

8.10 Congenital abnormalities and birth defects

We do not pay for treatment of any congenital abnormality or birth defect that had been diagnosed before the start date of your cover with us. This includes conditions such as a hole in the heart (Patent Foramen Ovale (PFO)) and genetic disorders such as Down's syndrome.

8.11 Cosmetic or reconstructive treatment

We do not pay for cosmetic or reconstructive treatment, whether or not it is needed for medical or psychological reasons, or any medical condition arising from that treatment. This means we do not pay for:

- treatment carried out to change appearance such as a facelift, remodelled nose or removal of a birthmark or tattoo;
- treatment of ptosis (drooping eyelids) unless this is caused by an **acute condition**;
- breast enlargement or reduction including surgery for gynaecomastia (a condition causing enlargement of male breasts) or any other treatment to change the shape or appearance of your breasts;
- treatment for scar revisions, including keloid scars; or
- treatment connected to previous cosmetic or reconstructive treatment.

We will pay for **treatment** to restore appearance if needed as a result of an accident and it takes place within 12 months of the date of the accident.

8.12 Critical care

We do not pay for any **critical care** that:

- follows an unplanned or emergency admission to an NHS hospital (including private patient units in an NHS hospital) or a private hospital;
- follows a transfer to an NHS hospital from a private hospital (whether or not it was an emergency admission);
- follows a transfer from an NHS critical care unit to a private critical care unit; or
- does not take place in a dedicated critical care unit.

8.13 Dental treatment

We do not pay for any dental treatment, including:

- dental check-ups, x-rays, scale and polish and hygienist fees. This cover is provided under benefit 7.5.1 (Routine dental costs) but only if it is included on the employee certificate;
- repair or replacement of damaged teeth using extractions, fillings, crowns, bridges and inlays. This cover is provided under benefit 7.5.1 (Routine dental costs) but only if it is included on the employee certificate;
- dentures, dental implants or any other dental prosthesis made by a laboratory technician;
- periodontal treatment (treatment of gum disease such as gingivitis);
- orthodontic treatment (aligning teeth) including any associated extractions; or
- cosmetic treatment, such as bleaching or teeth whitening.

We will pay for the oral procedures listed under benefit 7.1.5 (Dental surgery carried out by an oral specialist).

8.14 Dialysis

We do not pay for kidney dialysis or peritoneal dialysis as part of long-term treatment of chronic kidney failure.

We will pay for temporary, short-term dialysis associated with sudden secondary kidney failure arising out of an **acute condition** affecting another part of the body.

8.15 Drugs and dressings that are taken home after treatment

We do not pay for:

- drugs, medicines or dressings that are given to take home after **treatment** if they can be prescribed by a **GP** or bought without a prescription (for example, antibiotics, painkillers and bandages); or
- complementary or alternative therapy products or preparations, including, but not limited to, homeopathic remedies or substances.

8.16 Experimental or unproven treatment

We do not pay for treatment that is not based on **established clinical practice**. This includes treatment using any drug that is unlicensed or is being used outside the terms of its licence.

8.17 Eyesight and vision disorders

We do not pay for treatment, such as laser eye surgery, glasses and contact lenses, given to correct myopia (short sightedness), hypermetropia (long sightedness), astigmatism and other eyesight and vision disorders caused by a congenital abnormality, maturing or ageing. This cover is provided under benefit 7.5.3 (Optical costs) but only if it is included on the employee certificate.

We will pay for **treatment** of eyesight and vision disorders arising out of an **acute condition**, such as cataracts and detached retina.

8.18 Failure to follow medical advice

We do not pay for treatment arising from a failure to protect yourself from disease, illness and injury by not following specific medical advice given to you by your **GP** or any other medical professional involved in your treatment and general medical care.

This includes not taking prescribed medication and not making lifestyle changes that have been considered necessary for the prevention of future disease, illness or injury.

8.19 Failure to take reasonable care to prevent disease, illness or injury from occurring

We do not pay for treatment needed for an illness or injury where the circumstances leading to that illness or injury were the result of your own actions. This includes:

- self-inflicted illness or injury or attempted suicide;
- putting yourself in needless danger that could reasonably be predicted unless you were trying to save someone's life;
- taking part in criminal activity or public disorders such as driving whilst under the influence of drugs or alcohol;
- being under the influence of drugs, alcohol or other intoxicating substances to the extent that your judgement was seriously affected; and
- treatment of injuries resulting from a road traffic collision if you were not wearing a crash helmet, seat belt or suitable child restraint.

8.20 GP charges and primary care treatment

We do not pay for:

- treatment provided by a **GP**. This cover is provided under benefit 7.5.4 (Private GP costs) but only if it is included on the employee certificate;
- home visits carried out by a **GP**; or
- administration fees charged by a **GP** for completing a claim form or supplying other documents needed to support a claim.

8.21 Gender reassignment/gender confirmation

We do not pay for treatment for, resulting from, or related to, gender reassignment or gender confirmation.

8.22 Hazardous and dangerous activities

We do not pay for any treatment arising from your participation in a **hazardous activity**.

8.23 Hearing disorders

We do not pay for treatment (including hearing tests, hearing aids and cochlear implants) related to any hearing disorder such as deafness or tinnitus caused by a congenital abnormality, maturing or ageing.

8.24 Healthy tissue removal

We do not pay for the removal of healthy tissue which is not diseased or the removal of surplus or fat tissue such as abdominoplasty (tummy tuck), or liposuction, whether or not the treatment is needed for medical or psychological reasons.

8.25 Infertility investigations and assisted reproduction

We do not pay for treatment arising from you not being able to conceive naturally, infertility or low fertility. This includes:

- **diagnostic tests** to look for the cause of recurrent miscarriages;
- treatment to prevent future miscarriage;
- any form of assisted reproduction; or
- any treatment needed as a result of these investigations or treatments.

8.26 Mental health care

We do not pay for treatment of any acute mental or psychiatric illness. This cover is provided under benefit 7.4 (Mental health care) but only if it is included on the employee certificate.

8.27 No GP referral

We do not pay for any treatment if you have not been referred by your **GP** or if your **GP** indicates that a referral for treatment is not necessary.

8.28 Non-medical costs

We do not pay costs that are not directly related to **treatment** of an **acute condition** including:

- charges for cancelled, missed or late appointments;
- domestic costs such as home help or childcare;
- personal travel costs to and from the place of treatment including car parking fees;
- personal expenses such as newspapers, laundry, phone calls and additional meals whilst you are in hospital;
- non-medical admissions where you have been admitted to hospital because you need help with mobility, personal care or feeding; and
- extra accommodation costs because you need to go into hospital early or leave hospital later than usual after **treatment** has finished because of your personal social or domestic circumstances.

8.29 Overseas treatment

We do not pay for treatment you receive outside the **United Kingdom**.

8.30 Pre-existing conditions

We do not pay for **treatment** of any **pre-existing condition** or **related condition**. More information on how we may accept **pre-existing conditions** is given in chapter 11 of this guide.

8.31 Pregnancy and childbirth

We do not pay for:

- pregnancy or childbirth. We will pay for the pregnancy complications listed under benefit 7.1.3 (Pregnancy complications);
- ending a pregnancy unless this is essential for medical reasons where the life of the mother is at risk if the pregnancy goes to full term; or
- treatment of an embryo or foetus.

8.32 Professional sports

We do not pay for any treatment needed as a result of training for or taking part in any sport for which you:

- are paid;
- receive a grant or sponsorship (excluding travel costs); or
- are competing for prize money.

This exclusion does not apply if you are coaching the sport.

8.33 Rehabilitation, convalescence and general nursing care

We do not pay for rehabilitation, convalescence or occupational therapy or for treatment received in a health hydro, nature cure clinic or similar establishment, or in a private bed registered as a nursing home and attached to or run by such an establishment.

8.34 Screening, monitoring and preventative treatment

We do not pay for:

- precautionary or voluntary health checks, health screenings, fitness testing or genetic testing where you do not have any symptoms of an **acute condition** but undergo a series of tests to find out if you have an **acute condition** or are at risk of having an **acute condition** in the future;
- vaccinations, including travel vaccinations;
- ongoing monitoring of a **chronic condition**; or
- preventative treatment such as surgery to remove one or more organs (such as the breasts and ovaries) where there is no sign of **cancer** if the removal is to prevent future development of **cancer** in that organ.

8.35 Sexual dysfunction

We do not pay for treatment arising from or related to sexual problems, impotence, genital warts or sexually transmitted diseases.

8.36 Sleep disorders and sleep problems

We do not pay for treatment relating to sleep apnoea (temporarily stopping breathing during sleep), snoring, insomnia and other sleep related disorders.

8.37 Transplants

We do not pay for treatment involving any form of transplant surgery, including organ transplant, organ prosthesis (such as an artificial heart or lung) and transplant of body parts.

We will pay for skin grafts when carried out as part of **treatment** of an **acute condition**.

8.38 Unqualified or unrecognised specialists, therapists and complementary medicine practitioners

We do not pay for treatment provided by a specialist, therapist, complementary medicine practitioner or any other medical professional who is not recognised by us as having specialised knowledge of, or expertise in, the treatment of the relevant disease, illness or injury, or who is not registered with the relevant governing and regulatory body in accordance with current legal requirements.

8.39 Varicose veins

We do not pay for treatment of varicose veins of the leg unless:

- the vein size is 4.5mm or greater in diameter measured by ultrasound immediately below the saphenofemoral or saphenopopliteal junction; or
- for incompetent perforating veins, the vein diameter has been measured by ultrasound at 3.5mm or greater.

In addition, at least one of the following clinical criteria must also be met:

- they are causing ankle oedema (swelling) of venous origin;
- there is established lipodermatosclerosis or progressive skin changes;
- there have been recurrent episodes of superficial thrombophlebitis;
- there has been more than one episode of minor haemorrhage from a ruptured superficial varicosity or one episode of a significant haemorrhage from a ruptured superficial varicosity;
- a trial of continuous compression therapy prescribed by your **GP** for at least six months has failed; or
- there is active or healed venous ulceration.

We may need to contact your **GP** or **specialist** for further information about your condition before we can confirm cover.

8.40 Warts and verrucae

We do not pay for treatment of warts or verrucae.

8.41 Weight loss treatment

We do not pay for treatment related to weight loss including bariatric (weight loss) surgery such as a gastric band, gastric bypass or sleeve gastrectomy (see also exclusion 8.24 Healthy tissue removal).

8.42 War, contamination and pandemics

We do not pay for treatment of any illness or injury resulting from:

- acts of terrorism, war, invasion, riot, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution or similar event;
- nuclear, biological or chemical contamination; or
- pandemic disease and/or epidemic disease.

9. Excesses

The employee certificate will tell you if this policy has an excess and how much it is. If this policy does have an excess, we will deduct this amount from the first valid invoice we receive and from any subsequent valid invoices until the excess has been fully applied.

We will tell you when we have done this and you will then need to pay the excess amount to the relevant provider.

9.1 What is an excess?

An excess is the amount that must be paid before we make any payment for treatment covered by this policy.

9.2 How does the excess apply?

The excess applies 'per insured person, per **period of insurance**'. This means each insured person covered under this policy will only pay an excess once during a single **period of insurance** regardless of how many claims they make during that **period of insurance**.

9.3 What happens if treatment spans two periods of insurance?

An excess has to be paid at the start of the first eligible claim made in a **period of insurance**. If that claim continues into the next **period of insurance**, another excess will need to be paid.

9.4 What if this policy transferred from another insurer?

If this policy has transferred from another insurer, or from another policy provided by us, the benefits, terms and conditions of this policy will apply. This may mean an excess now applies to a claim that did not apply under the previous policy or that the amount or type of excess has changed.

9.5 How do I settle the excess?

You must pay any excess direct to the relevant provider. We cannot accept payment directly from you.

9.6 How does the excess affect benefits with monetary limits?

If you pay an excess for treatment costs that normally have a maximum limit, we will not take the excess you pay off the amount of the limit.

9.7 Does the excess apply to NHS or maternity cash benefit claims?

You do not need to pay an excess towards any claim for NHS cash benefit or maternity cash benefit.

10. Making a claim

We want to make the process of making a claim as simple as possible. We aim to answer any questions or concerns you may have about your claim in a caring and efficient way.

10.1 See your GP

If you are feeling unwell or suffering from any injury, you must first see your **GP** for advice. Your **GP** will carry out some investigations to decide the best course of action which may require you to be referred to a **specialist** for **treatment**.

If your **GP** wants to refer you to a **specialist** for **treatment**, tell your **GP** you have medical insurance and private treatment would be preferred.

Your **GP** will write a referral letter to the **specialist** detailing the history of your symptoms, their own assessment of your symptoms (including the results of any tests carried out) and the reason for the referral.

10.2 Call the claims helpline

If your **GP** refers you for private **treatment**, you must then call our claims helpline to find out if your claim will be covered by this policy and, if so, any limits that apply. You may find it useful to have your documents with you when calling the claims helpline.

We will ask you for information about your condition and proposed **treatment** including:

- your name and policy number;
- the symptoms you are suffering from and whether you have had these symptoms before;
- when the symptoms first began and when you first visited your **GP** for these symptoms; and
- what the **GP** is recommending along with the name of the **specialist** you are being referred to and the hospital you will be going to.

We will also ask you to send us a copy of the **GP's** referral letter.

Depending on the information you give us, we may ask your **GP** for further information. We will ask for your consent to do this. You do not have to give consent, but without it we may not be able to continue with the claim.

If we accept the claim, we will give you a claim number and let you know what you need to do next.

10.3 When you see the specialist

At your first appointment with the **specialist**, pass on the claim number and any other correspondence from us about the claim.

The **specialist** will talk to you about the best way of treating your symptoms. When you have more information about the **treatment** the **specialist** is recommending, you must contact us again so we can confirm if the **treatment** is covered by this policy and, if so, any limits that apply. We may ask your **specialist** for further information.

10.4 If you need inpatient or daypatient treatment

It is particularly important to contact us straightaway if the **specialist** says you need **inpatient** or **daypatient treatment** as specific limits may apply. We may also ask your **specialist** to provide further information about the **treatment** before we agree cover.

10.5 Payment of invoices

We prefer to settle invoices directly if we can. If you receive any invoice yourself, send it to us immediately so we can arrange settlement.

10.6 Claims for NHS cash benefit

NHS cash benefit is only paid if you choose to receive **treatment** in an NHS hospital as an alternative to using a private hospital. Claims for NHS cash benefit do not need to be pre-authorised.

To claim NHS cash benefit, you must send us a copy of the hospital's discharge summary within six months of being discharged.

10.7 Claims for routine dental, optical and GP costs

Claims for dental, optical and **GP** costs do not need to be pre-authorised. To make a claim for these costs, send us the original, fully itemised invoice from the dentist, optician or **GP** along with a written request for reimbursement, quoting your policy number. We do not settle these claims directly with the providers. You can also submit your dental, optical, and GP costs claim through our online portal which can be found on our website at www.freedomhealthinsurance.co.uk.

10.8 Refunding costs you have already paid and NHS cash benefit

If we are refunding costs you have already paid, or making a payment for NHS cash benefit, the payment will always be sent to the member.

All payments will be made in pound sterling and we will not add interest or any other extra fees to any payment we make.

10.9 Timescales for submitting claims

We prefer to settle invoices directly with the providers, but if you do pay any invoices yourself, you must send them to us within six months along with a written request for reimbursement.

If you do not send your claim within six months, we will not reimburse you.

10.10 What happens if you are covered by another policy?

If you have any other insurance that may also cover medical expenses, we will only pay a proportionate share of the claim. This is usually referred to as 'dual insurance' although the legal term is 'contribution'.

If your claim involves dual insurance, you must give us full details of the other policy, including the name and address of the other insurer, their policy and claim number, and any other relevant information.

We will contact the other insurer and recover a proportion of the costs.

10.11 What happens if your claim relates to an injury or medical condition that was caused by another person?

If your illness or injury was caused or made worse by someone else, we may have a legal right to recover our costs from that person. This is usually referred to as a 'third party claim' although the legal term is 'subrogation'.

In this situation, you must immediately tell us and provide all relevant information and help that we need to make a third party claim.

If you are pursuing a personal claim for damages against the third party, you must provide us with the name and address of the solicitor acting on your behalf. We will contact the solicitor to register our interest and seek to recover our own costs, plus interest, in addition to any damages you may recover or be awarded.

You (or your solicitors) must keep us fully informed on the progress of your claim and the outcome of any action or settlement discussions and not do anything that would prejudice our subrogation rights.

If you recover any compensation (whether or not through legal action) that includes medical treatment costs we have paid on your behalf, you must repay those costs to us within 21 days along with any interest you have also been awarded. If you only receive a proportion of your claim for damages, you should repay the same proportion of our costs.

If we choose, we also have the right, in your name but at our expense, to:

- take over the defence or settlement of any claim; and
- start legal action to recover our costs from a third party.

If we do take legal action in relation to your claim then you must agree to reasonably assist us in pursing that legal action.

10.12 The Private Healthcare Information Network

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

11. Pre-existing medical conditions

As with any type of insurance policy, we only provide cover for unexpected new events that first arise after the start of cover with us rather than for events that have already happened or can be predicted to happen.

Therefore, we do not cover '**pre-existing conditions**'. These are medical conditions you had before your cover with us started. Most private medical insurance policies have the same restriction.

This means any medical condition (including symptoms and undiagnosed conditions and other related conditions) that you experienced in the five years before your cover with us started will not be covered unless we have agreed to provide cover for that medical condition.

The process we use to see if you have a **pre-existing condition** is called 'underwriting'. There are several methods of underwriting available and these are explained below. The method of underwriting that applies to each insured person will be shown on the employee certificate.

11.1 Full medical underwriting (FMU)

We do not pay for **treatment** of any **pre-existing condition** unless we were told about that **pre-existing condition** in your application form and we have not added an **endorsement** to the employee certificate to state that the **pre-existing condition** is not covered.

If we later find you are receiving **treatment** for a condition that was not reported to us on your application form, we have the right to:

- get more information about that condition from you, your **GP**, your **specialist** or any other person involved in your **treatment**; and
- withdraw or suspend any agreement we have already given to cover the costs of **treatment** for that condition.

If, when we receive that information, we think you did not provide all the information you knew at the time you completed the application form, we can apply an additional **endorsement** from your **start date** and reconsider the claim in light of the new **endorsement**.

If the claim is no longer eligible as a result of the new **endorsement**, we will recover from you any payments we have already made for that claim.

If we think you deliberately failed to provide information to get cover you knew you were not entitled to, we may take any action we have a legal right to take.

11.2 Moratorium underwriting

We do not pay for **treatment** of any **pre-existing condition** – all **pre-existing conditions** are automatically excluded from cover.

If you do not receive medical advice or **treatment** for, take medication for or experience symptoms of the **pre-existing condition** for a full, unbroken two-year period after the **moratorium date**, cover for that **pre-existing condition** may then be available. This is known as the 'moratorium period'.

If you receive further medical advice, **treatment** or medication or experience further symptoms of that condition any time within the two-year period, the moratorium period will start again. This is sometimes referred to as a 'rolling moratorium'.

Any **pre-existing condition** that needs regular **treatment** or medical advice will never be covered.

11.3 Continued personal medical exclusions (CPME)

If your cover transferred to us from another policy which full medical underwriting originally applied to, we will cover all **pre-existing conditions** unless the employee certificate says otherwise.

If your previous policy included an **endorsement**, it will continue under this policy with us and will be shown on the employee certificate.

11.4 Switch moratorium underwriting

If your cover has transferred to us from another policy which had a moratorium, we will take over the remaining moratorium period.

11.5 Medical history disregarded (MHD)

We will cover all eligible **pre-existing conditions**.

Important note about transferring cover from a previous insurer

If you transfer to this policy from another insurer, remember that the rules and benefits of this policy may be different from those of the previous policy. Transferring to us does not mean you can claim the same benefits as those on the previous policy and we do not guarantee we will continue to pay for **treatment** that started, and may have already been paid for, under a previous policy.

You must call the claims helpline before receiving any further medical **treatment** to make sure you are covered by this policy.

12. General conditions

These are conditions that relate to the administration of the claims process, this policy and the group scheme in general.

12.1 About the group scheme

The group scheme is a legal contract between the policyholder and the underwriter. Under the contract, the underwriter agrees to pay the cost of medical treatment an insured person receives in line with the cover requested by the policyholder for that insured person.

In return, the policyholder agrees to pay the premium to the underwriter when it becomes due.

If the underwriter does not enforce, or delays enforcing, any contract term, condition or exclusion under the group scheme, this will not prevent the underwriter from enforcing that term, condition or exclusion later.

12.2 Sanctions Suspension Clause

It is a condition of this group scheme that the provision of any cover or benefit, or the payment of any claim, will be suspended if, by providing any cover or benefit or paying a claim, we or the underwriter would be exposed to any sanction, prohibition, or restriction under any United Nations' resolution(s) or the trade or economic sanctions, laws, or regulations of the European Union, United Kingdom or United States of America.

The suspension will continue until we and the underwriter would no longer be exposed to any sanction, prohibition, or restriction.

12.3 Making changes to the group scheme

Only the underwriter or the policyholder can change or cancel the group scheme and you do not have any legal right to enforce any part of it. You are, however, given the right to make a claim or a complaint in your own name as if you were the policyholder.

12.4 Payment of premium

The policyholder is responsible for making sure the premium is paid to us on time. If a premium is not paid on time, we will stop payment of claims until the overdue premium is paid in full. If premiums remain unpaid we may cancel the group scheme.

12.5 GP registration and referral

Unless otherwise stated, cover under this policy requires you to be referred by your **GP** before starting **treatment**. Therefore, you should ensure you are registered with a **GP** in the **UK** and that the **GP** has easy access to your full medical records. This will help avoid unnecessary delay in obtaining pre-authorisation for a claim from us.

12.6 Pre-authorisation of a claim

All claims must be pre-authorised before you start **treatment** so we can confirm your claim will be covered. If you incur additional costs because a claim was not pre-authorised, we will not pay those additional costs.

12.7 Providing us with information

It is your responsibility to provide us with information we need to help us assess your claim and administer the group scheme. For example, we may ask you for:

- medical reports and other information about your **acute condition** and **treatment**;
- the results of any independent medical examination we ask you to undergo at our expense; and
- original accounts and invoices in connection with your claim, including any that are related to costs covered by your excess.

Any cost associated with supplying us with the information needed to support your claim will be your responsibility.

You must make sure any information given to us is true, accurate and complete. If we later find out we have been given false or incomplete information, we can cancel your cover under the group scheme or apply a new or amended **endorsement** to reflect the correct information.

12.8 The underwriter's liability under this policy

The underwriter's liability is limited to paying the cost of **treatment** of an **acute condition** that is covered by this policy. There is no contractual relationship between the underwriter and any medical services provider and all payments are made on your behalf. The underwriter carries no legal liability for settlement of any treatment costs which remains with you until the costs are paid.

Neither we nor the underwriter makes any representation about the availability or quality of any service provided by any provider.

Neither we nor the underwriter will be held liable for any loss, harm or damage that comes from the lack of availability or a defect in the quality of any treatment provided by a medical services provider. If you are unhappy with the service provided, you should raise this directly with the provider. You can ask us not to pay costs on your behalf if you wish, but you will remain liable for these costs until they are settled.

12.9 Ex-gratia payments

An ex-gratia payment is an amount we agree to pay towards the cost of treatment that is not normally covered under this policy.

Any ex-gratia payment we make will still be subject to any relevant benefit limit and excess that applies to this policy.

If we make an ex-gratia payment, this does not set a precedent for making another ex-gratia payment in similar circumstances in the future.

13. Who can be covered by this policy?

This section explains the rules for membership of the group scheme.

13.1 Who can be included under the group scheme

Only the policyholder can decide who can be covered under the group scheme. Any changes, such as the addition of a new dependant, must be authorised by the policyholder and agreed by us first.

If the policyholder agrees, this policy can cover:

- the member;
- the member's partner (husband, wife, civil partner or partner who permanently lives at the same address as the member); and
- the member's or the member's partner's children (including adopted children) who normally live at the same address as the member.

13.2 Age limits for children

Children can be covered up to the end of the **period of insurance** during which they reach 30 years of age. The child will then be removed from this policy but may have the opportunity to transfer to an individual policy.

13.3 Adding new dependants to this policy

The member can add a new partner or child to this policy by filling in an application form and sending it to the group secretary to send on to us. We will send the member a new employee certificate to confirm the change and any **endorsements** that apply.

13.4 Newborn babies

The member can add a newborn baby to this policy without having to supply any medical evidence as long as we are told within three months of the child's birth. Otherwise the member will need to fill in an application form and **endorsements** may apply.

13.5 Change of address

The member must tell us if they change address as we will send any relevant correspondence, including information about changes to this policy, to the last known address. Any changes will apply even if the member does not receive the details we send.

13.6 Moving abroad

The member must tell us immediately if any insured person moves abroad. We may be able to offer to transfer the insured person to our Freedom Worldwide contract.

13.7 When cover under this policy will end

Only the policyholder or we can cancel or change your cover under this policy. Your cover will end if:

- you move abroad;
- we or the policyholder decide you can no longer be covered under the group scheme; or
- we or the policyholder cancel the group scheme.

We may also cancel or change your cover if you have:

- misled us by giving false or incomplete information in relation to a claim or your cover in general under the group scheme;
- made or helped anyone else make a fraudulent claim; or
- not kept to the terms and conditions or not acted honestly in your dealings with us.

We can backdate this cancellation or change. If we cancel your cover for any of these reasons, we will send written notice to the policyholder's last known address. We may also recover any claims we have paid.

If the cover for the member ends, the cover for all other insured persons listed on the employee certificate will end at the same time.

We will not pay the costs of any further **treatment** you receive after the date your cover ends even if:

- the claim had already started before your cover ended;
- you are in the middle of a course of **treatment**; or
- we have already been told about, and authorised, further **treatment**.

13.8 Transferring cover to an individual policy

We will offer the opportunity to transfer cover to an individual policy to:

- members leaving or retiring from the policyholder;
- children who have reached 30 years of age; and
- the widow or widower of a deceased member.

A transfer is only available if:

- the person who wants an individual policy applies within 30 days after their cover under the group scheme ends; and
- the individual policy starts as soon as their cover under the group scheme ends.

It is your responsibility to contact us to arrange to transfer cover to an individual policy – we will not contact you directly.

14. How to make a complaint

At Freedom Health Insurance, our customers have the right to expect excellent customer service at all times. However, from time to time, things can go wrong and, when they do, we want you to tell us.

14.1 How to contact Freedom Health Insurance

Phone: **0800 999 2013** or **01202 756 350**

Email: **complaints@freedomhealthinsurance.co.uk**

Post: **County Gates House, 300 Poole Road, Poole, Dorset BH12 1AZ**

We will investigate your complaint and provide you with our final decision within no more than eight weeks.

If you remain unhappy with our response, or if we have not replied within eight weeks, you may have the right to refer your complaint to the Financial Ombudsman Service.

14.2 About the Financial Ombudsman Service (FOS)

The Financial Ombudsman Service provides a free and independent service for resolving complaints with financial services firms. The FOS will only consider your complaint if you have given us the opportunity to resolve the matter first and you must refer your complaint to the FOS within six months of our final decision letter.

If you do not refer your complaint in time, the FOS will not have our permission to consider your complaint and so will only be able to do so in very limited circumstances. For example, if the FOS believes the delay was as a result of exceptional circumstances.

14.3 How to contact the Financial Ombudsman Service

Phone: **0800 023 4567** or **0300 123 9 123**

Post: **Exchange Tower, Harbour Exchange, London, E14 9SR**

More information about the Financial Ombudsman Service is available on its website at **www.financial-ombudsman.org.uk**

If you contact the FOS, this does not affect your right to take legal action if you are dissatisfied with, and do not accept, the outcome of the review.

15. Financial Services Compensation Scheme

The underwriter is a member of the Financial Services Compensation Scheme (FSCS). The FSCS may assist if it believes the underwriter cannot meet its liabilities under this policy. The FSCS may arrange to transfer a policy to a new insurer, provide a new policy or pay compensation. The maximum level of compensation is 90% of the claim with no upper limit.

Further information about the FSCS is available on the FSCS website at **www.fscs.org.uk** or by phone on **0800 678 1100** or **020 7741 4100**.

16. How we use your personal information

If you have any queries concerning our data protection policy, write to the Chief Operating Officer at Freedom Health Insurance.

16.1 Confidentiality and protecting your information

Freedom Health Insurance will deal with all personal information supplied to us in the strictest confidence. We will comply with all requirements of current data protection legislation.

We may appoint a third party to assist with the administration of claims. Any third party we appoint will only process personal information for the sole purpose of administering a claim and in line with our instructions and all processing carried out on our behalf is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by current data protection legislation.

From time to time, it may be necessary to process personal information outside of the European Economic Area (EEA) – for example, in order to guarantee payment of medical treatment costs in an overseas hospital. We will take reasonable steps to ensure personal information is protected.

16.2 How we will use personal information

The information we receive in connection with a policy, including any claims made under that policy, will be held by us, on behalf of the underwriter, for the purpose of providing and managing the insurance cover available under that policy. This includes:

- processing claims and making payments on behalf of an insured person;
- obtaining further information about an insured person's condition and treatment plan from their GP, specialist, hospital or any other medical practitioner involved in their treatment;
- sharing information with another insurer to recover our proportionate share of treatment costs in relation to a 'dual insurance' claim;
- sharing information with a solicitor or another third party to recover our costs in relation to a 'third party' claim;
- producing statistics to help us assess how our policies are used to enable us to develop future products and services.

To help the policyholder review a group scheme, we may include details of claims paid in anonymised statistical reports we send to the group secretary and any broker appointed by the policyholder.

We will not give medical information to anyone unless we have been given permission or we are allowed to by law.

16.3 Information about family members

If a member gives us personal information about another insured person for the purpose of administering a policy or making a claim, we will assume that the member has the insured person's consent to do so.

Most correspondence about a policy, including claims correspondence, will be sent to the member because the policy will be in their name. If any insured person over 18 years of age does not want us to do this, they should let us know. It may be preferable for that insured person to apply for their own policy in their own name.

16.4 Preventing and detecting fraud

To protect the interests of all our customers, we will share information with external fraud prevention agencies to enable the detection and prevention of fraudulent and improper claims. This may include:

- sharing information about an insured person with other organisations and public bodies including the police where we have reasonable grounds to suspect that fraudulent claims may have been made;
- checking the details fraud prevention agencies hold about an insured person; and
- carrying out credit searches and searches of databases set up by the insurance industry to identify fraud.

If we are given false or inaccurate information and we suspect fraud, we will pass details to fraud prevention agencies. In addition, the policy may be cancelled, we will not pay the claim and we may report the matter to the policyholder and the police.

16.5 Requesting information

An insured person can ask for a copy of the information we hold about them and ask us to correct any mistakes in the information.

16.6 Passing information to other third parties

Other than for the sole purpose of administering a policy, or as required by law, we do not pass any personal information on to any third party for marketing purposes.

16.7 Destruction of personal information

We will hold information for a reasonable period of time (usually no more than two years) after a policy has ended. It will then be destroyed in a secure and confidential manner.

17. Definitions (words with special meanings)

A word or term that appears in bold print in this guide has the meaning given below.

17.1 Accidental dental injury

A natural and otherwise sound tooth or teeth being broken or knocked out as a result of:

- a sudden, unexpected, violent and direct blow to the jaw; or
- biting on an unexpected hard item in food (for example, stones in sandwiches or in fruit sold as not having stones).

You must be able to tell us when, where and how the injury happened.

17.2 Accident or emergency admission

An admission to:

- a hospital directly following an accident;
- a hospital ward directly from the emergency department for **emergency treatment**; or
- a hospital ward on the same day as a referral for **emergency treatment** is made either by a GP or specialist.

17.3 Active cancer treatment

Treatment intended to affect the growth of the **cancer** by shrinking it, stabilising it or slowing the spread of the disease.

17.4 Acute condition

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.

17.5 Cancer

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

17.6 Chronic condition

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

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

17.7 Critical care

Any **treatment** given in an intensive care unit (ICU), intensive therapy unit (ITU), coronary care unit (CCU), high dependency unit (HDU), paediatric intensive care unit (PICU), neonatal intensive care unit (NICU), special care baby unit (SCBU) or similar unit providing an equivalent level of specialist care, wherever provided.

17.8 Daypatient

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

17.9 Diagnostic tests

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

17.10 Emergency treatment

Unforeseen and unplanned treatment that is needed for the sudden onset of an **acute condition** which, for medical reasons, cannot be delayed and requires you to be admitted to hospital urgently and immediately.

17.11 Endorsement

Any change to the terms listed in this guide as shown on the employee certificate. This can take the form of:

- a specific **pre-existing condition** not being covered;
- an extra premium to cover a **pre-existing condition** (this must be agreed by the policyholder); or
- any other change to our standard terms and conditions.

You can ask us to reconsider any **endorsement** within the first 30 days of each **period of insurance**.

17.12 Established clinical practice

Treatment that is:

- appropriate for the signs, symptoms, diagnosis or treatment of the medical condition;
- representative of best clinical practice in the UK as defined by relevant regulatory and professional bodies;
- proven, through clinical trial, to be safe and effective in providing positive health outcomes and is supported by peer-reviewed and published evidence;
- practiced widely throughout the UK and is routinely available on the NHS;
- not part of a clinical trial or generally regarded as being unsafe, unproven or ineffective; and
- not being provided primarily for the convenience of an insured person or any other healthcare professional involved in the treatment.

17.13 General Practitioner (GP)

A medical practitioner who is registered and licensed with the General Medical Council in general practice.

17.14 Group secretary

The person that manages the group scheme on behalf of the policyholder.

17.15 Hazardous activity

For the purposes of this policy, hazardous activities include:

- flying (including hot-air ballooning, hang gliding, gliding and micro-lighting) other than as a fare-paying passenger in a licensed passenger aircraft;
- martial arts, boxing, wrestling or judo;
- mountaineering, abseiling, rock climbing requiring the use of ropes and/or guides, pot-holing and bungee-jumping;
- parachuting, free-fall parachuting, parasailing or parascending;
- gymnastics;
- any form of swimming/diving at a depth of 30 metres or more;
- any form of swimming using breathing apparatus;
- water-skiing;
- use of a weapon or firearm;
- off-piste skiing or snowboarding.

This list is not exhaustive and is indicative of the type of activity we would consider to be hazardous. Please contact us to check whether we could cover a particular activity that could be considered hazardous.

17.16 Inpatient

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

17.17 Moratorium date

The date your cover started on a moratorium underwriting basis as shown on the employee certificate.

17.18 Outpatient

A patient who attends a hospital, consulting room or outpatient clinic and is not admitted as a **daypatient** or an **inpatient**.

17.19 Period of insurance

Typically a period of 12 months starting from the commencement date and ending on the cover end date shown on the employee certificate.

17.20 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 in the five years before the **start date** or **moratorium date** (if applicable) of your cover under this policy, whichever is the earlier.

17.21 Related condition

A symptom, illness or injury which reasonable medical opinion considers is the cause of, or is arising from, the illness or injury that needs **treatment**.

17.22 Specialist

A medical or dental practitioner who, at the time you receive **treatment**:

- has received specialist training in a specific branch of medicine and holds the relevant qualifications;
- is a full member of their recognised professional body;
- is fully licensed and currently registered to practise according to relevant legislation;
- is included in the Specialist Register kept by the General Medical Council (GMC) for their relevant speciality; and
- holds, has held or would be allowed to hold a consultant position, in their relevant speciality, in an NHS hospital.

17.23 Start date

The date your cover first started with us as shown on the employee certificate.

17.24 Treatment

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

17.25 United Kingdom

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