Freedom
Health Insurance

Essentials

Policyholder's Guide to Cover

Contents

1. Welcome to Freedom Health Insurance

Welcome and thank you for choosing 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 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 your cover.

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

This policy is underwritten by HDI Global Specialty SE, Starr International (Europe) Limited (SIEL) and HCC International Insurance Company plc ('HCCII') trading as Tokio Marine HCC.

HDI Global Specialty SE. HDI Global Specialty is authorised and regulated by BaFin. Authorised by the Prudential Regulation Authority. Subject to regulation by the Financial Conduct Authority and limited regulation by the Prudential Regulation Authority. Details about the extent of our regulation by the Prudential Regulation Authority are available from HDI Global Specialty SE on request. (FRN: 659331) HDI Global Specialty SE is registered in Germany (commercial register number HRB 211924) and has its registered office at HDI Platz 1, 30659 Hannover, Germany, and its UK branch office at 20 Gracechurch Street, London, EC3V 0BA, United Kingdom.

HCC International Insurance Company plc ('HCCII') trading as Tokio Marine HCC. HCCII is registered in England and Wales, (Company Reg No: 01575839) with its registered office at 1 Aldgate, London EC3N 1RE. HCCII is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and Prudential Regulation Authority (Firm Reference Number 202655).

Starr International (Europe) Limited, registered office address 30 Fenchurch Avenue, London EC3M 5AD, United Kingdom. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Firm reference Number: 676783.

This policy is administered on behalf of the underwriter by Freedom Health Insurance.

2. How to contact Freedom Health Insurance

Your policy number is shown on the 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 the next working day.

Making a claim

Phone: **01202 283 580**

Fax: **01202 756 351**

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

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**

Call 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.

All written correspondence should be sent to:

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

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.

3. About the policy documents

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

3.1 Certificate of insurance

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

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

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

3.2 Policyholder's Guide to Cover (this booklet)

This booklet is the Policyholder's Guide to Cover. It describes the benefits provided and any limits which apply. It also 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.

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

We do 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.

4. How to read this Policyholder's Guide

We know insurance policies can 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 which have a specific meaning when used in a particular context. A full list of these words, together with their meanings, can be found in chapter 20 (Definitions).

4.1 Rights and responsibilities

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

A contract is agreed between an individual person, who took out the insurance on behalf of themselves and their dependants, and the insurance company which provides the cover requested under the contract. When we refer to the person who took out the insurance, 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 'policy'.

Freedom Health Insurance administers this policy on behalf of the underwriter. So when we refer to Freedom Health Insurance, we use the terms 'we', 'us' and 'our'.

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

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

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

5. About Freedom Essentials

Freedom Essentials is a health insurance policy designed to provide benefits which help meet the cost of elective, short-term medical **treatment**, provided by a **specialist**, which you need because you are suffering from an unexpected **acute condition**.

5.1 Freedom Essentials and the National Health Service (NHS)

Having a health insurance policy 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.

Freedom Essentials does not do everything the NHS does and there are some key areas where this policy does not provide cover. These include:

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

5.2 What is a pre-existing condition?

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

More information about **pre-existing conditions** is given in chapter 11 (Pre-existing conditions).

5.3 What is an acute condition?

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

An **acute condition** responds 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**. Health insurance is intended to cover **treatment** of **acute conditions**.

5.4 What is treatment?

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

- diagnose acute symptoms to see what is causing them;
- to cure an **acute condition** to stop it coming back; or

to bring symptoms of an **acute condition,** or an acute flare-up of a **chronic condition**, under control and to minimise their effect when a full cure is not possible.

Health insurance only pays for **treatment** given in line with **established clinical practice** which is widely available on the NHS because it has been shown to work and is not considered experimental or unproven.

5.5 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.

5.6 Acute flare-ups of a chronic condition

We will cover short-term **treatment** to resolve an acute flare-up of a **chronic condition**. An acute flare-up 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 do 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** which 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?

Freedom Essentials has a mandatory 'core cover' and cancer cash benefit included in all policies. It also offers an optional outpatient treatment benefit.

6.1 Core cover (included in all policies)

The core cover is primarily designed to provide benefits which help meet the cost of planned, elective **inpatient** and **daypatient treatment**. It pays a **fixed cash benefit** so you can arrange **treatment** under a **self-pay contract** at a hospital of your choice in the **United Kingdom** or overseas.

This core cover also includes **inpatient** and **daypatient treatment** for certain complications of pregnancy, certain dental surgery and a cash benefit if you have **inpatient** or **daypatient treatment** through the NHS.

6.2 Cancer cash benefit (included in all policies)

Freedom Essentials does not provide cover for the cost of **cancer treatment**. We will provide a cash benefit if, as part of a course of **active cancer treatment**, you have an **inpatient** or **daypatient procedure** or have chemotherapy or radiotherapy.

6.3 Outpatient treatment (optional cover)

Freedom Essentials offers an optional outpatient treatment benefits package. If you are covered for **outpatient treatment**, it will be shown on the certificate. If it is not shown on the certificate, you do not have this cover even though it is mentioned in this guide.

All **outpatient treatment** must take place in the **United Kingdom**.

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. Health insurance is intended to provide cover for planned, elective **treatment** and this policy does not provide cover for **accident and emergency services**.

If you need further **treatment** after the **emergency treatment** has finished, call the claims helpline as we may be able to provide cover for this.

Important note

More detailed information about the benefits is given in chapter eight (What does this policy cover?).

You should also read chapter nine (Exclusions – what is not covered by this policy) for more information about the things which are not covered.

7. How does the excess work?

The 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 from the first amount we pay and from any subsequent payments we make until the excess has been fully applied.

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

7.1 What is an excess?

An excess is the amount we deduct from the first eligible claim made by an insured person in each **period of insurance**.

7.2 How does the excess apply?

The excess applies once to each insured person during each **period of insurance**. This means each insured person on this policy will only pay an excess once during a single **period of insurance** regardless of how many claims they make during the same **period of insurance**.

7.3 What happens if treatment spans two periods of insurance?

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

7.4 How do I settle the excess?

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

7.5 How does the excess affect benefits with monetary limits?

If you pay an excess for **treatment** costs which have a maximum limit, we do not take the excess you pay off the amount of the limit.

8. What does this policy cover?

Depending on the cover you have, we will pay the benefits provided by this policy to investigate, diagnose and treat an **acute condition** as long as:

- you are named on the certificate we have issued to the policyholder for the **period of insurance** in which **treatment** takes place;
- the policyholder has paid all premiums which 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, a **specialist**;
- **treatment** is given in line with **established clinical practice**;
- 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**.

8.1 Core cover

This policy will include the core cover. We do not pay any more than the annual limit shown on the certificate for all benefits combined which are provided under this section. If there is an annual limit, it will be shown on your certificate.

8.1.1 Inpatient and daypatient treatment (where a procedure is required)

We will pay a **fixed cash benefit** towards the cost of **inpatient** and **daypatient treatment** needed to treat an **acute condition** where a **procedure** is required.

Treatment must be carried out by a **specialist** in a hospital under a **self-pay contract** which includes **aftercare**.

8.1.2 Inpatient and daypatient treatment (where no procedure is required)

We will pay a cash benefit of £200 for each night or day spent in hospital for **inpatient** and **daypatient treatment** needed to treat an **acute condition**, but where no **procedure** is required.

Treatment must be carried out by a **specialist** in a hospital under a **self-pay contract** which includes **aftercare**.

Important information about the benefit payment

The **fixed cash benefit** we pay for **inpatient** and **daypatient treatment** is based on the national average cost (excluding central London hospitals) of the same **procedure** when carried out under a **self-pay contract**.

If there is a surplus after you have paid all the bills, this is yours to keep.

If you have **inpatient** or **daypatient treatment** in a more expensive hospital, such as one based in London, you may find the **fixed cash benefit** will not cover the cost in full and you will be responsible for settling the difference yourself. Depending on which hospital you use, this could be a significant amount of money so we suggest you get quotes from several hospitals before committing to the **treatment**.

Examples of the benefit amounts we pay can be found on our website at **www.freedomhealthinsurance.co.uk/essentials/procedure-payment-guide.**

Multiple procedures

If you have more than one **procedure** during the same hospital stay, we may increase our benefit payment to allow for the extra costs of the additional **procedures** where it is appropriate to do so.

No procedure(s)

If you have **inpatient** or **daypatient treatment** where no procedure is required, we will only pay a maximum of £200 for each day or night spent in hospital which will not cover the cost of your **treatment** in full. You will be responsible for paying the hospital costs yourself which could be a significant amount of money. Again, we suggest you get quotes from several hospitals before committing to the **treatment**.

Using the NHS

If you use the NHS for **inpatient** or **daypatient treatment**, we will pay the NHS cash benefit described under section 8.1.5 (NHS cash benefit).

Going overseas

Using the **fixed cash benefit**, you can choose to have your **inpatient** or **daypatient treatment** anywhere in the world. If the cost of **treatment** is lower than the **fixed cash benefit**, you can keep the surplus but if the cost is higher, you will be responsible for the balance.

The costs of travelling overseas, such as flights, transport and accommodation, remain your responsibility and we do not pay extra benefit towards these costs.

We do not pay for **treatment** of complications which arise from receiving **treatment** outside of the **United Kingdom** or for the cost of returning to the **United Kingdom** (repatriation) for further **treatment**.

8.1.3 Pregnancy complications

We will pay a **fixed cash benefit** towards the cost of **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.

Caesarean sections

We do not provide benefit towards the cost of a planned or emergency Caesarean section.

Outpatient treatment

Related **outpatient treatment** costs will be covered in line with the outpatient treatment benefit (*see 8.3 Outpatient treatment*).

8.1.4 Dental surgery

We will pay a **fixed cash benefit** towards the cost of **inpatient** and **daypatient** dental 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

Related **outpatient treatment** costs will be covered in line with the outpatient treatment benefit (*see 8.3 Outpatient treatment*).

8.1.5 NHS cash benefit

We will pay 50% of the **fixed cash benefit** we would pay under benefit 8.1.1 (*Inpatient and daypatient treatment (where a procedure is required)*) if you receive elective **inpatient** or **daypatient treatment** which 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 **accident and emergency services**.

8.1.6 MRI, CT and PET scans

We will pay, in full, the fee charged by a hospital or other diagnostic imaging facility in the **United Kingdom** which is approved by us for providing the following scans when you are 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 requested by your **GP**.

8.2 Cancer cash benefit

This policy does not provide cover for the cost of **cancer treatment**.

We will provide a cash benefit if, as part of a course of **active cancer treatment**, you need a **procedure** or undergo chemotherapy or radiotherapy.

8.2.1 Inpatient and daypatient treatment (where a procedure is required)

We will pay 50% of the **fixed cash benefit** we would pay under benefit 8.1.1 (*Inpatient and daypatient treatment (where a procedure is required)*) if you need an **inpatient** or **daypatient procedure** as part of a course of **active cancer treatment**.

8.2.2 Chemotherapy and radiotherapy

We will pay £150 for each hospital visit to receive chemotherapy or radiotherapy as part of a course of **active cancer treatment**.

8.3 Outpatient treatment

If this policy includes this cover, it will be shown on the certificate along with the annual benefit limit.

All **outpatient treatment** must take place in the **United Kingdom**.

8.3.1 Diagnostic tests requested by your GP

We will pay, in full, up to £500, the fee charged by a hospital, or other diagnostic imaging facility approved by us, for **diagnostic tests** requested by your **GP** without being referred to a **specialist** first.

We do not pay for MRI, CT or PET scans requested by your **GP**.

8.3.2 Specialist fees including consultations and diagnostic tests

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

The fees include:

- consultations with the **specialist**; and
- **diagnostic tests**;

We do not pay for repeat **diagnostic tests** your **GP** has already carried out.

8.3.3 Physiotherapy treatment (on GP or specialist referral)

We will pay, in full, up to the limit shown on the certificate, 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 to the physiotherapist, we will pay up to a maximum of six sessions of **treatment** during a single **period of insurance**.

The physiotherapist must be recognised by us, a member of the Chartered Society of Physiotherapy (CSP) and registered with the Health and Care Professions Council (HCPC).

The physiotherapist must not be you or a member of your family.

8.3.4 Outpatient procedures

We will pay a **fixed cash benefit** towards the cost of **outpatient treatment** needed to treat an **acute condition** where a **procedure** is required.

Treatment must be carried out by a **specialist** in a hospital under a **self-pay contract**.

The annual benefit limit for outpatient treatment does not apply.

8.3.5 Routine dental costs

We will refund, in full, up to a maximum of £150, 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.

The annual benefit limit for outpatient treatment does not apply.

See also exclusion 9.14 Dental treatment.

8.3.6 Routine optical costs

We will refund, in full, up to a maximum of £150, 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 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.

The annual benefit limit for outpatient treatment does not apply.

See also exclusion 9.18 Eyesight and vision disorders.

8.3.7 Maternity cash benefit

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

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

The annual benefit limit for outpatient treatment does not apply and we do not deduct the excess from this payment.

9. Exclusions – what is not covered by this policy

This section of the guide lists the exclusions which apply to all Freedom Essentials policies. However, this policy may include cover for some of these exclusions depending on the specific cover you have.

9.1 Accident or emergency services

We do not pay for **accident and emergency services** provided by any NHS or private hospital, urgent care centre or other similar facility.

9.2 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).

9.3 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.

9.4 Allergies

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

9.5 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, braces and special bedding;
- 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.

9.6 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.

9.7 Cancer treatment

We do not provide cover for **treatment of cancer** apart from the cover provided under benefit 8.2 (Cancer cash benefit).

9.8 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.

9.9 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.

9.10 Complications caused by excluded conditions and treatment

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

9.11 Complications following overseas treatment

We do not pay for **treatment** of complications which arise after **inpatient** or **daypatient treatment** which took place outside of the **United Kingdom** or the cost of returning to the **United Kingdom** for further **treatment**.

9.12 Congenital abnormalities and birth defects

We do not pay for **treatment** of a congenital abnormality or birth defect which 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.

9.13 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 the **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 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 cover **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.

9.14 Dental treatment

We do not pay for any dental **treatment**. This includes:

- dental check-ups, x-rays, scale and polish and hygienist fees. This cover is provided under benefit 8.3.5 (Routine dental costs) but only if it is included on the certificate;
- repair or replacement of damaged teeth using extractions, fillings, crowns, bridges and inlays. This cover is provided under benefit 8.3.5 (Routine dental costs) but only if it is included on the 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 provide benefit towards the cost of the surgical procedures listed under benefit 8.1.4 (Dental surgery).

9.15 Dialysis

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

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

9.16 Drugs and dressings taken home after treatment

We do not pay for:

- drugs, medicines or dressings 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 such as homeopathic remedies and substances.

9.17 Experimental or unproven treatment

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

9.18 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 8.3.6 (Routine optical costs) but only if it is included on the certificate.

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

9.19 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 medical advice given 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 which have been considered necessary for the prevention of future disease, illness or injury.

9.20 Failure to proceed with inpatient or daypatient treatment

We do not pay for **treatment** of any **acute condition** or **chronic condition** which is the result of not proceeding with pre-authorised **inpatient** or **daypatient treatment** which has been recommended by a **specialist** within a reasonable period of time (no more than six months).

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

We do not pay for **treatment** of an **acute condition** where the circumstances leading to the **acute condition** were the result of your own actions. This includes:

- self-inflicted illness or injury or attempted suicide;
- putting yourself in needless danger which could reasonably be predicted unless you were trying to save someone's life;
- taking part in criminal activity or public disorder (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 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.

9.22 Gender reassignment/gender confirmation

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

9.23 GP charges and primary care treatment

We do not pay for:

- **treatment** provided by a **GP**;
- 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.

9.24 Hazardous and dangerous activities

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

9.25 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.

9.26 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 it is needed for medical or psychological reasons.

9.27 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**.

9.28 Mental health care

We do not pay for **treatment** of acute mental or psychiatric illness.

9.29 No GP referral

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

9.30 Non-medical costs

We do not pay costs which are not directly related to **treatment** of an **acute condition**. This includes:

- 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** such as taxi fares, car parking fees and private ambulance;
- flights, transport and accommodation if you travel overseas for **treatment**;
- 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;
- 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.

9.31 Pre-existing conditions

We do not pay for **treatment** of a **pre-existing condition** or **related condition**. More information about **pre-existing conditions** is given in chapter 11 (Pre-existing conditions).

9.32 Pregnancy and childbirth

We do not pay for:

- pregnancy or childbirth. We will provide benefit towards the cost of **treatment** of the pregnancy complications listed under benefit 8.1.3 (Pregnancy complications);
- Caesarean sections;
- 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;
- **treatment** of an embryo or foetus; or
- **treatment** received within three months of birth by a child born as a consequence of any form of human-assisted reproduction.

9.33 Professional sports

We do not pay for **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.

9.34 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 facility, or in a private bed registered at a nursing home.

9.35 Screening, monitoring and preventative treatment

We do not pay for:

- precautionary or voluntary health checks, health screenings or fitness testing where you do not have 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**, such as **cancer**, in the future;
- all genetic testing and screenings;
- 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 the organ.

9.36 Sexual dysfunction

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

9.37 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.

9.38 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 cover skin grafts when carried out as part of **treatment** of an **acute condition**.

9.39 Unqualified or unrecognised providers

We do not pay for **treatment** provided by any person or at any facility which is not recognised by us as having specialised knowledge of, or expertise in, the relevant disease, illness or injury, or who is not registered with the relevant governing and regulatory body in line with legal requirements.

9.40 Varicose veins

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

a) the vein size is 4.5mm or greater in diameter measured by ultrasound immediately below the saphenofemoral or saphenopopliteal junction; or

b) 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.

9.41 Warts and verrucae

We do not pay for **treatment** of warts or verrucae.

9.42 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 9.26 Healthy tissue removal)*

9.43 War, contamination, pandemics and natural disasters

We do not pay for **treatment** of any disease, 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.

10. How do I make 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 health 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 which 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 which apply. We may ask your **specialist** for further information.

10.4 If you need inpatient or daypatient treatment

It is important to contact us straightaway if the **specialist** says you need **inpatient** or **daypatient treatment**. We may also ask your **specialist** to provide further information about the **treatment** before we agree to continue with the claim.

We pay you a **fixed cash benefit** towards the cost of **inpatient** and **daypatient treatment** which should be arranged as a **self-pay contract**.

10.4.1 Arranging treatment at a private hospital

Contact the hospital and ask for a quote for the **inpatient** or **daypatient treatment** under a **self-pay contract**. We suggest you contact several hospitals, including NHS hospitals which offer private **treatment**, to get the best value for money. When you have booked the **treatment** at your chosen hospital, send us a copy of the **self-pay contract** confirming the cost of the **treatment** and what **aftercare** is included.

10.4.2 Fixed price package or fee per service

Most private hospitals will offer fixed price packages where the cost of the **treatment** and all associated services are fixed according to individual circumstances. Should you wish to take advantage of a fixed price package, you can negotiate this directly with the hospital.

Some hospitals may not give a fixed price package if you need an unusual or complex **treatment** or if your medical circumstances make it difficult to know how much medical care will cost. In these circumstances, you will be billed on a 'per item' basis.

10.4.3 Multiple procedures

If you have more than one **procedure** during the same hospital stay, we will increase our **fixed cash benefit** to allow for the extra costs of the additional **procedure** where it is appropriate to do so.

10.4.4 Payment of the hospital invoice

You must make it clear to the hospital this is a **self-pay contract** and the hospital should charge on this basis and send you the invoice. This means you will be responsible for paying the invoice directly to the hospital and the hospital may insist on full payment before treatment takes place.

We will make every effort to send the **fixed cash benefit** to you before this happens, but it will not always be possible depending on when **treatment** is scheduled to take place. In these situations, we will endeavour to send the **fixed cash benefit** to you as soon as possible.

10.4.5 Using the NHS

If you use the NHS for **inpatient** or **daypatient treatment**, you must let us know before **treatment** takes place and send us a copy of the booking letter. After you have been discharged from hospital, you will need to send us a copy of the discharge letter and any medical reports we ask for so we can validate the claim before paying any NHS cash benefit which is due.

10.4.6 Going overseas

If you travel outside the **United Kingdom** to receive **inpatient** or **daypatient treatment**, you must send us a copy of the booking letter, the hospital discharge letter and any medical reports we ask for.

10.5 Making payments

Unless we have agreed to pay the provider directly, all payments will be sent to the policyholder and will be made in pounds sterling. We do not add interest or any other extra fees to any payment we make.

10.6 Timescales for submitting claims

All claims must be sent to us within six months otherwise we will not make any payment.

10.7 What happens if you are covered by another policy?

If you have any other insurance which 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.

10.8 What happens if your claim relates to an injury or medical condition which 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 them. 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 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 to prejudice our subrogation rights.

If you recover any compensation (whether or not through legal action) which includes medical treatment costs we have paid on your behalf, you must repay those costs to us with 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 this legal action.

10.9 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 conditions

As with any type of insurance policy, we only provide cover for unexpected new events which first arise after the start of cover with us rather than for events which 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 health insurance policies have the same restriction.

This means any medical condition (including symptoms and undiagnosed conditions and other **related conditions**) you had in the five years before your cover with us started will not be covered unless we have agreed to provide cover for this 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 which applies to each insured person will be shown on the certificate.

11.1 Full medical underwriting (FMU)

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

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

- get more information about the 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 the condition.

If, when we receive the 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 any payments we have already made for the claim from you.

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 the **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 the condition any time within the two-year period, the moratorium period will start again. This is sometimes called a 'rolling moratorium'.

Any **pre-existing condition** which 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 certificate says otherwise.

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

If you transfer to this policy from another insurer, remember 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** which 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 and this policy in general.

12.1 About this policy

This policy is a legal contract between the underwriter and the policyholder. Under the contract, the underwriter agrees to provide the cover requested by the policyholder for each insured person.

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

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

12.2 Making changes to the cover provided by this policy

Only the underwriter or the policyholder can change or cancel this policy and no other insured person has any legal right to enforce any part of it.

Changes to the cover provided by this policy can only be made at the start of each **period of insurance**. If the policyholder wishes to change the level of cover provided by this policy, we may ask the policyholder to complete a new application form and we reserve the right to add new **endorsements** which relate to the change in cover.

12.3 Assignment (transfer) of cover

An insured person cannot transfer their cover under this policy to anyone else.

12.4 The law and language applying to this policy

This policy is a legal contract between the underwriter and the policyholder and is governed by the laws of England and Wales. Any claims or disputes arising in connection with the contract can only be decided by the courts of England and Wales.

The language used in this policy, and any communication relating to it, will be English.

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 **United Kingdom** 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.

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

You must provide us with any information we need to help us assess your claim and administer this policy. 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 which 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 this policy or apply a new or amended **endorsement** to reflect the correct information.

12.8 Failure to proceed with inpatient or daypatient treatment

If a **specialist** recommends **inpatient** or **daypatient treatment**, and we agree to provide cover under this policy, we require the **treatment** to take place within a reasonable period of time, usually no more than six months.

If you do not proceed with the recommended **inpatient** or **daypatient treatment**, we reserve the right to:

- add an **endorsement** to this policy which removes cover for the condition requiring **inpatient** or **daypatient treatment**, and any **related condition**, until **treatment** has taken place and you have fully recovered; and
- require you to repay any **fixed cash benefit** we have already paid you in respect of the recommended **inpatient** or **daypatient treatment**.

We also reserve the right to refuse to renew this policy.

12.9 The underwriter's liability under this policy

The underwriter's liability is limited to providing the benefits which are available under this policy. There is no contractual relationship between the underwriter and any medical services and 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 which 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.

12.10 Ex-gratia payments

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

Any ex-gratia payment we make will still be subject to any relevant benefit limit and excess which 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.

12.11 Sanctions Suspension Clause

It is a condition of this policy 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:

a) United Nations' resolution(s); or

b) 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.

13. Paying the premium

It is the policyholder's responsibility to make sure all premiums which are due are paid to us on time and in line with any invoice or other request for payment issued to the policyholder by us.

13.1 Payment of the premium

This policy is an annual contract, lasting for twelve months for which a full annual premium is due at the start of each **period of insurance**.

The premium can be paid in full at the start of the **period of insurance** by cheque, credit or debit card, direct debit or by bank transfer (details available on request).
The premium can also be paid by monthly direct debit.

13.2 The account the premium must be paid from

All premiums must be paid from an account held with a firm which is authorised and regulated by the Financial Conduct Authority and the Prudential Regulatory Authority (or its successor).

The premiums do not have to be paid by the policyholder (for example, the premiums can be paid by the policyholder's employer) but if the premiums are paid by any party other than the policyholder, they do not acquire any rights under this policy.

13.3 Insurance Premium Tax (IPT)

All premiums are inclusive of Insurance Premium Tax (IPT) at the current rate.

13.4 Late premiums

You can only make a claim when premiums which are due have been paid. If premiums are outstanding past their due date, we reserve the right to stop authorising new claims and settling invoices.

If premiums remain outstanding for more than 30 days after the due date, this policy will be cancelled from the date the premium is paid up to and no further payments will be authorised or made by us.

We will also recover the cost of any claims we have paid for treatment received during any period for which no premium has been paid.

13.5 Recovery of outstanding amounts

We reserve the right to pass any outstanding amounts to a debt collection agency.
Any additional costs from the debt collection agency will be charged to the policyholder.

14. Membership

This section explains the rules for membership of this policy.

14.1 Who can be included under this policy

Only the policyholder can decide who can be covered under this policy. Any changes, such as the addition of a new partner or child, must be authorised by the policyholder and agreed by us first.

If the policyholder agrees, this policy can also cover:

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

14.2 Age limits for children

Children can be covered up to the end of the **period of insurance** during which they reach 25 years of age. The child will then be removed from this policy but may have the opportunity to transfer to an individual policy.

14.3 Adding new dependants to this policy

The policyholder can ask us to add a new partner or child to this policy by filling in an application form and sending it to us. If we accept the application, we will send the policyholder a new certificate to confirm the change and any **endorsements** which apply.

14.4 Newborn babies

The policyholder 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 policyholder will need to fill in an application form and **endorsements** may apply.

14.5 Change of address

The policyholder 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 policyholder does not receive the details we send.

14.6 Moving abroad

The policyholder 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.

14.7 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 this policy; or
- we or the policyholder cancel this policy.

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 policy;
- 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 appropriate. 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 from you.

If the cover for the policyholder ends, the cover for all other insured persons listed on the 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**.

14.8 Transferring cover to an individual policy

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

- children who have reached 25 years of age; and
- the widow or widower of a deceased policyholder.

A transfer is only available if:

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

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

15. Renewing this policy

At least 21 days before the end of the **period of insurance**, we will send the policyholder an invitation to renew this policy for a further 12 months. This may be sent via the policyholder's broker if one has been appointed.

The renewal invitation will confirm the premium the policyholder must pay for the next **period of insurance** and give details of any changes made to the cover. It will also list the names of each insured person covered by this policy so the policyholder can check these are correct and make any changes which are needed.

If the policyholder pays the premium by direct debit, this policy will automatically renew on the terms we have offered in the renewal invitation unless the policyholder tells us otherwise. We will collect the new premium using the existing direct debit instruction at the start of the new **period of insurance**.

If the policyholder has not received the renewal invitation at least 14 days before the end of the **period of insurance**, contact us.

We do not guarantee to offer to renew this policy and if we do decide not to renew this policy for any reason, we will tell you, or the broker, at least 21 days before the end of the **period of insurance**.

16. Cancelling this policy

At the start of each **period of insurance**, the policyholder has 14 days to review our terms and decide whether to continue with this policy. This is often called 'the cooling-off period'.

If the policyholder decides not to continue with the policy, they can cancel it by letting us know through their appointed broker, or directly in writing, by email, or by phone using the contact details provided in chapter two 'How to contact Freedom Health Insurance' on page five of this guide. The policyholder should also ensure all insured persons are told this policy is cancelled and what, if any, alternative cover has been arranged.

We will refund any premiums the policyholder has paid as long as no claim has been made during the cooling-off period.

If the policyholder does not cancel this policy during the cooling-off period, it will continue for the rest of the **period of insurance**. The policyholder must pay a full annual premium although we may allow this to be paid in instalments.

16.1 Cancelling this policy during a period of insurance

If the policyholder decides to cancel the policy during a **period of insurance** after the cooling-off period has ended, they can cancel it by letting us know through their appointed broker, or directly in writing, by email, or by phone using the contact details provided in chapter two 'How to contact Freedom Health Insurance' on page five of this guide. The policyholder should also ensure all insured persons are told this policy is cancelled and what, if any, alternative cover has been arranged.

If no claim has been made in the **period of insurance**, we may refund any premium which has been paid for the rest of the **period of insurance**.

If a claim has been made, we will cancel this policy but we will not refund any premium and the policyholder must pay us the rest of the full annual premium for the **period of insurance**.

16.2 Our right to cancel this policy

We may also cancel or change the policy if the policyholder has:

- not paid the premium which is due;
- misled us by giving false or incomplete information; or
- not kept to the terms and conditions or not acted honestly in its dealings with us.

We will also cancel the policy if we no longer offer this plan at the renewal date. We will offer an alternative plan, if we have one, in order for cover to continue.

17. 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:

17.1 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.

17.2 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.

17.3 How to contact the Financial Ombudsman Service

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

Online: **www.financial-ombudsman.org.uk/contact-us/complain-online**

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.

18. 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 this 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**.

19. How we use personal information

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

19.1 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.

19.2 How we will use personal information

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

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

19.3 Information about family members

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

Most correspondence about this policy, including claims correspondence, will be sent to the policyholder because this 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 the insured person to apply for their own policy in their own name.

19.4 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.

19.5 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.

19.6 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.

19.7 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.

19.8 HDI Global Specialty SE privacy notice

HDI Global Specialty SE is a joint data controller. You can get a copy of its privacy notice at www.hdi.global/legal/privacy.

20. Definitions (words with special meanings)

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

20.1 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.

20.2 Accident or emergency services

Treatment provided by any NHS or private hospital, urgent care centre or other similar facility, including, but not limited to:

- **emergency treatment** which takes place following an accident;
- admission to hospital on the same day as a referral for **emergency treatment** is made either by a **GP** or **specialist**;
- an admission to a hospital ward directly from the accident and emergency department (or equivalent) for **emergency treatment**; or
- an admission to a hospital ward for emergency treatment after being repatriated to the **United Kingdom** from overseas.

20.3 Active cancer treatment

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

20.4 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.

20.5 Aftercare

Treatment needed following **inpatient** or **daypatient treatment** such as:

- a follow-up consultation with the **specialist** or physiotherapy **treatment** to help with recovery; or
- **treatment** for unforeseen complications.

If these costs are included in the self-pay contract, we will not make any further payment.

If these costs are not included in the **self-pay contract**, we may make an additional payment in line with the terms and conditions of your policy.

20.6 Cancer

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

20.7 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;
- it comes back or is likely to come back.

20.8 Critical care unit

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.

20.9 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.

20.10 Diagnostic tests

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

20.11 Emergency treatment

Unforeseen and unplanned **treatment** needed for the sudden onset of an **acute condition** which, for medical reasons, cannot be delayed and requires urgent and immediate **treatment**.

20.12 Endorsement

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

- a specific **pre-existing condition** or other 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**.

20.13 Established clinical practice

Treatment which is:

- appropriate for the signs, symptoms, diagnosis or **treatment** of the medical condition;
- representative of best clinical practice in the **United Kingdom** 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 **United Kingdom** and is routinely available through the NHS;
- not part of a clinical trial or generally regarded as being unsafe, unproven or ineffective; and
- is not being provided primarily for the convenience of an insured person or other any healthcare professional involved in the **treatment**.

20.14 Fixed cash benefit

The amount we pay for **inpatient** and **daypatient treatment** based on the national average cost (excluding central London hospitals) of the same **treatment** when carried out under a **self-pay contract**.

20.15 General Practitioner (GP)

A medical practitioner who is registered and licensed with the General Medical Council in general practice, and who name appears in the GP Register.

20.16 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 aircraft.
- Martial arts, boxing, wrestling or judo.
- Mountaineering, abseiling, indoor and outdoor rock climbing and bouldering, 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. Contact us to check whether we could cover a particular activity which could be considered hazardous.

20.17 Inpatient

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

20.18 Moratorium date

The date your cover started with the first insurer which provided cover for you on a moratorium underwriting basis, as shown on the certificate.

20.19 Outpatient

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

20.20 Period of insurance

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

20.21 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.

20.22 Procedure

An operation or **diagnostic test** which is carried out by, or under the direct control of, a **specialist** and is listed under the Procedural Schedule held by the Clinical Coding & Schedule Development (CCSD) Group.

The CCSD Procedural Schedule can be found at
www.ccsd.org.uk/ccsdschedule/ccsdschedulechapter/

20.23 Related condition

A symptom, illness or injury which reasonable medical opinion considers is the cause of, or is arising from, another symptom, disease illness or injury.

20.24 Self-pay contract

An agreement between you and a hospital to provide **inpatient** or **daypatient treatment** at your personal cost irrespective of the amount of **fixed cash benefit** you receive from us. The contract should be an all-inclusive arrangement covering the following services:

- 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 make sure you are fit to receive **treatment**;
- **specialist** fees;
- hospital fees such as accommodation, meals and nursing care, **critical care unit**; operating theatre; all drugs and , consumables, any internal implanted prosthesis such as a joint replacement, and all other medical services provided whilst in hospital such as **diagnostic tests** and physiotherapy; and
- **aftercare.**

20.25 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 practice 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.

The **specialist** must not be you or a member of your family.

20.26 Start date

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

20.27 Treatment

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

20.28 United Kingdom

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

Notes

Freedom Health Insurance is a trading name of Freedom Healthnet Limited.
Freedom Healthnet Limited is authorised and regulated by the Financial Conduct Authority with the registration number 312282.
Registered address: County Gates House, 300 Poole Road, Poole, Dorset BH12 1AZ. Company registration number: 04815524.